

SECTION 3.1  
PARTICIPATING HOSPITALS



# MEDICARE 1967

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- 3.1: Participating Hospitals
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## Foreword

WITH THE enactment of the health insurance program for the aged (Medicare), it became possible to organize a continuing information system to report the use of health care services by older Americans. Since Medicare began, one of the basic tasks has been to process and pay claims for covered medical services submitted by or on behalf of the almost 19.5 million persons entitled to hospital insurance benefits and the 17.8 million persons enrolled for supplementary medical insurance benefits. From this operation come data on the amount, the kind, and the cost of such services used by the aged.

This report is one in a series of publications designed to disseminate such data on a regular basis. It provides detailed statistical information on hospitals participating under Medicare. Other reports in the series will present the number and characteristics of participating home health agencies, extended care facilities, independent laboratories, of the insured population, and the utilization of medical care services. A listing of these reports appears on the inside cover. The reports are intended to give a comprehensive account of the amounts reimbursed under the program, the kinds of services paid for, and the variations in utilization and reimbursement by age, race, and sex

of the beneficiary, as well as his place of geographic residence. Such data can provide new insights into the patterns of medical care for persons aged 65 and over. A fuller understanding of present practice can contribute to improved health services not only for the aged but for the general population of the United States as well.

Many individuals in the Social Security Administration have assisted with the development of this series. The preparation of these reports is a major function of the ORS Division of Health Insurance Studies under the supervision of Howard West, director, and Aaron Krute, deputy director, and involving a majority of its staff. Important contributions for the tabulation and presentation of the statistical content of this report were made by Frank L. Kirby, Charles G. Scott, and Theodosia Rasberry of the Statistical Processing and Procedures Branch of that division. Text preparation was the responsibility of David Allen, chief of the Provider Statistics Branch. Special acknowledgments for publication services are made to the Division of Operating Facilities in the Office of Administration, and to the Division of Health Insurance Statistical Data of the Bureau of Data Processing and Accounts for tabulating services.

IDA C. MERRIAM

*Assistant Commissioner for Research and Statistics*

OCTOBER 1971



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# The Statistical System

THIS PUBLICATION is a section of a statistical report series produced from Medicare program records. Presented on a calendar year basis, describing services rendered in the year, the series includes sections on enrollment, characteristics of providers, inpatient care in hospitals and extended care facilities, outpatient hospital services, home health services, physicians' and other medical services, and overall summaries.

The primary objective of these reports is to provide data required to measure and evaluate program operation and effectiveness. Benefit payment operations furnish information about the amount and kind of hospital and medical care services used by persons aged 65 and over, as well as the expenditures for such services. The applications by hospitals, extended care facilities, home health agencies, and independent laboratories to participate in the program provide data on the characteristics of such providers of services. The claim number assigned to each individual serves as the link between the program services utilized and the demographic characteristics of each individual recorded in the health insurance entitlement master file.

The data-collection system has two inherent characteristics that determine the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid under the program and, for a sample of beneficiaries, records of diagnoses and surgical procedures are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, costs, and the like, all program statistics are centrally prepared.

## THE BASIC RECORDS

The statistical system is based on five related computer-tape records: the health insurance entitlement master file, provider record, hospital insurance (Part A) utilization record, medical insurance (Part B) payment record, and the record containing information from medical insurance bills for a 5-percent sample of supplementary medical insurance enrollees.

## THE HEALTH INSURANCE ENTITLEMENT MASTER FILE

The health insurance entitlement master file identifies each aged person eligible for health insurance benefits and indicates whether he is entitled to hospital benefits, to supplementary medical insurance benefits, or to both of these benefits.

This record is used to create a health insurance card that is sent to each insured person. The card contains the individual's claim number (the number used for OASDI or railroad retirement programs). It indicates the entitlement of the individual for the two parts of the Medicare program.

The entitlement record provides the population data for each part of the program and therefore serves as the base for the computation of a variety of utilization rates, limited only by its demographic content.

## PROVIDER RECORD

Every hospital, home health agency, extended care facility, and independent laboratory must apply for participation in the hospital insurance program in order to be reimbursed for services provided. Data included on the application forms have been recorded in the central provider record and are updated as facilities are recertified periodically, as new ones apply for participation, or as some leave the program. When the information in this provider file is combined with utilization data, it serves to relate the characteristics of facilities and agencies that provide care to the kinds and amounts of service used by persons insured under Medicare.

## UTILIZATION RECORD FOR HOSPITAL INSURANCE

The administration of the hospital insurance program requires that two items of information be known about each person at the time of his admission to a hospital—his entitlement under the program and the extent to which he has used the benefits available to him under the "benefit period" concept.

When the patient is admitted to a hospital, the admission section of the inpatient hospital admission and billing form is completed by the hospital and forwarded through its intermediary to the Social Security Administration for recording in the central record. As soon as the record is checked, normally in less than 24 hours, the intermediary is informed of the patient's benefit status and of the number of days remaining during the "benefit period."

This information is then forwarded to the hospital. At discharge, the hospital completes the billing section of the form and sends it to the intermediary for payment. When approval for payment has been made, the intermediary forwards the claim to the Social Se-

# of the Medicare Program

curity Administration for inclusion in the central record.

As part of this process, information on diagnoses and surgical procedures are coded for a 20-percent sample of beneficiaries based on specific combinations of digits in the health insurance claim number. Copies of admission and billing forms are handled in a comparable manner by home health agencies and extended care facilities. The outpatient billing form is also transmitted to the Social Security Administration for recording in the central record after the bill is approved for payment by the intermediary.

All the information on utilization experience in hospital and extended care facilities that is needed to administer the "benefit period" provision is recorded in the central record. This information includes stays in certain nonparticipating institutions that meet the definition of a hospital or extended care facility under the law, and days of care not covered or reimbursable under the program.

Each admission and billing form contains both the beneficiary's claim number and the provider's identification number. The resulting tape record can be readily matched to the beneficiary files and the provider files. By this process, a statistical tape record is created for the sample of insured persons that contains all the available information needed for tabulation from the three files related to Part A utilization.

## PAYMENT FOR MEDICAL INSURANCE

Payment or reimbursement under the SMI program is made only after receipt by the carriers (intermediaries involved in Part B of the Medicare program) of bills having allowed charges exceeding \$50 during a calendar year period.

For the insured population, carriers need to know from a central source that the deductible has been met; thereafter, during the remainder of the calendar year, the only additional information required from the Social Security Administration for reimbursement or payment purposes is whether the person is still enrolled under the SMI program.

For administration and operation of the program, the Social Security Administration must have accurate and complete information on the amounts paid by the carriers for physician services and for other services and supplies under this part of the program. To meet these needs, carriers furnish a payment record consisting of tape, punched card, or other machine-readable record of each bill paid. A "bill" is defined as a request for payment from or on behalf of a beneficiary as the result of services provided by a

single physician or supplier.

The payment record also contains selected items of information needed to supply an efficient basis for drawing samples of the bills. These items provide a sampling frame that may be used to draw additional samples designed to obtain specific information not furnished reliably by the basic sample of enrolled persons under the medical insurance program.

## THE MEDICAL INSURANCE SAMPLE

Although the payment record provides a rapid method for summarizing payment data and a sampling frame for efficiently drawing additional samples of bills, it does not provide specific data on diagnoses, procedures, and related charges.

Basic statistics on the utilization of physician and other services covered under the supplementary medical insurance program are derived from bills paid by intermediaries to or on behalf of a continuous 5-percent sample of all enrolled persons. Intermediaries have been given specific combinations of digits of the health insurance claim number to be used in selecting the 5-percent sample, which is a sub-sample of the 20-percent sample used for hospital insurance program data.

Bills are submitted either directly on an SSA request for payment form, or on the SSA form in combination with the physician's billing form. Both methods are designed to provide information on the date and place of each service, the procedure carried out or service provided, the condition treated (diagnosis), and the physician's or supplier's charge for the specific service.

All of the bills of persons in the 5-percent sample to or for whom payment is made under the program, including those used to meet the annual \$50 deductible, are included in the sample and coded. However, data are not available through these procedures for persons in the sample who do not meet the \$50 deductible. Such data are collected by means of the Current Medicare Survey, with data made available in a separate report series.<sup>1</sup>

For hospital-based physicians who have authorized the provider to collect the fee for their services, the provider billing for patient services by physicians form is used. This form is completed for each patient. It includes descriptive information on the date and place of each service, the diagnoses, procedures, and the charges. These bills are received centrally for the 5-percent sample of persons enrolled for supplementary medical insurance.

<sup>1</sup> Jack Scharff, "Current Medicare Survey: The Medical Insurance Sample," *Social Security Bulletin*, April 1967.



## Hospitals Participating in the Medicare Program

TITLE XVIII of the Social Security Act, introduced as part of the 1965 amendments, provides health insurance protection for the aged. To implement the law, two separate but complementary programs were established. The first of these, the hospital insurance (HI) program, provides protection against the cost of hospital and related post-hospital care. The second, termed supplementary medical insurance (SMI), provides coverage of physicians' services and a number of other health items and services not included under the HI program. Among the major benefits provided are inpatient and outpatient hospital services.

Hospitals certified to provide services to Medicare beneficiaries include short-term general and specialty hospitals; tuberculosis, psychiatric, and other long-term general and specialty hospitals; and Christian Science sanatoriums. To participate in the program and be reimbursed for services provided, a hospital must meet statutory requirements and be in substantial compliance with conditions established by the Secretary of Health, Education, and Welfare, in the interest of the health and safety of patients.<sup>1</sup> To complete the requirements for participation, the hospital must enter into an agreement with the Social Security Administration not to charge for covered items and services, except deductibles and coinsurance amounts, and to reimburse the patient where such charges have been made in error. The hospital must also agree to provide services on a nondiscriminatory basis in accordance with Title VI of the Civil Rights Act of 1964.<sup>2</sup>

Hospitals are considered in substantial compliance with the conditions of participation if:

1. The hospital is accredited by the Joint Commission on Accreditation of Hospitals, and has established a utilization review plan, and such plan is in effect on or before the first day a hospital becomes a participating provider, or
2. The hospital meets the statutory requirements (Section 1861 (e) of the Act) and is found to be operating in accordance with all conditions of participation with no significant deficiencies, or
3. The hospital meets the specific statutory requirements of Section 1861 (e) of the Act, but is found to have deficiencies with respect to one or more conditions which:
  - a. It is making reasonable plans and efforts to correct, and
  - b. Notwithstanding these deficiencies, is rendering adequate care without hazard to the health and safety of individuals being served, taking into account special procedures or precautionary measures that have been, or are being, instituted.

This report presents data on selected characteristics of the hospitals that met the conditions for participation in the Medicare program at any time during calendar year 1967. Changes made by subsequent amendments to the Social Security Act or regulations are not covered, since they did not become effective until after this period.

During calendar year 1967, 6,959 hospitals in the United States and outlying areas had been certified to provide hospital services to the population 65 years of age and over covered by hospital insurance under Medicare. This represents a net increase over 1966 of 169 hospitals and 11,924 adult beds in the United States and outlying areas. Most of the increase—165 facilities and 11,230 beds—occurred in the 50 States and the District of Columbia. The largest relative and actual increases were registered in the South, where the South Atlantic, East South Central, and West South Central States added 41, 24, and 37 hospitals, respectively—a total of 102 hospitals in all.

The approximately 1.15 million adult beds in these institutions were available to the general population as well as to Medicare enrollees. The discussion in this report is limited to the distribution of certified facilities as they are related to the Medicare population.

<sup>1</sup> For the statutory definition of a "hospital," and the detailed conditions of participation, see the Code of Federal Regulations, Title 20, Chapter III, Part 405, "Conditions of Participation: Hospitals" (HIR-10), Social Security Administration.

<sup>2</sup> See "Conditions of Participation."

## Types and Characteristics of Hospitals

Most of the certified hospitals (just over 90 percent) were general and specialty hospitals classified as short-stay facilities reporting an average length of stay of less than 30 days (table A). Such hospitals contained two-thirds of the beds in certified hospitals. The remaining certified hospitals were long-stay facilities where the average length of stay is 30 days or more. Data for specialized long-stay hospitals serving tuberculosis and psychiatric patients are shown separately from data for all other long-stay hospitals, which include general hospitals, chronic disease, and other specialty long-term hospitals.

TABLE A.—Number and percentage distribution of participating hospitals and beds, all areas, 1967

Type of hospital	Hospitals		Beds	
	Number	Percentage distribution	Number	Percentage distribution
All areas.....	6,959	100.0	1,161,615	100.0
Short-stay.....	6,299	90.5	779,908	67.1
Long-stay.....	660	9.5	381,707	32.9
Tuberculosis.....	123	1.8	26,305	2.3
Psychiatric.....	348	5.0	314,528	27.1
Other.....	189	2.7	40,874	3.5

*American Hospital Association data.*—The number of hospitals, both in the aggregate and by type, and number of beds shown in this report differ from comparable figures for calendar year 1967 reported by the American Hospital Association in the annual Guide Issue of *Hospitals*, which listed the characteristics of member hospitals as of September 30, 1967.<sup>3</sup> The Social Security Administration figures do not include those hospitals denied participation, and those not applying for certification. The American Hospital Association does not register hospitals with fewer than six beds; there is no such limitation for participation under the Medicare certification requirements. Osteopathic hospitals are excluded from AHA membership, but can be certified under Medicare. In addition, the participating hospitals include about 100 general hospitals that are actually distinct parts of psychiatric and tuberculosis hospitals representing the active-care medical and surgical beds in these facilities which, as an entire institution, are not accredited by the Joint Commission on Accreditation of Hospitals. In some instances, active-care psychiatric units of the same hospitals may also be counted here as psychiatric hospitals. A number of medical centers are counted as one hospital while, in other cases, different components of the medical centers are counted separately, depending on the way in which certification was requested.

*Type of control.*—Fifteen percent of all participating hospitals are controlled by proprietary (or profit-making) organizations, 53 percent by voluntary (nongovernment) organizations, and the remainder

by State and local governments (table B). The distribution by control is much the same for short-stay hospitals as for all hospitals since they represent over 90 percent of the total number of hospitals.

TABLE B.—Percentage distribution of participating hospitals, by type of hospital, and control, all areas, 1967

Type of control	All hospitals		Short-stay hospitals	Long-stay hospitals		
	Number	Per cent		Tuber- culosis	Psychi- atric	Other
Percentage distribution						
All areas.....	6,959	100.0	100.0	100.0	100.0	100.0
Voluntary.....	3,698	53.2	56.3	5.7	17.8	43.9
Proprietary.....	1,039	14.9	15.2	1.6	17.5	10.1
State <sup>1</sup> .....	530	7.6	3.4	51.2	62.1	18.0
Local.....	1,692	24.3	25.1	41.5	2.6	28.0
All areas.....	6,959	100.0	90.5	1.8	5.0	2.7
Voluntary.....	3,698	100.0	95.9	0.2	1.7	2.2
Proprietary.....	1,039	100.0	92.1	0.2	5.9	1.8
State <sup>1</sup> .....	530	100.0	40.9	11.9	40.8	6.4
Local.....	1,692	100.0	93.4	3.0	0.5	3.1

<sup>1</sup> Includes 3 Federal hospitals not shown in detail.

The ownership pattern of long-stay hospitals is quite different, however. The majority are run by State and local governments; the proportion of voluntary and proprietary agencies is smaller than for short-stay hospitals. Because of the differences in their functions, distribution, and characteristics, data for the short-stay and long-stay hospitals are discussed separately.

### SHORT-STAY HOSPITALS

Short-stay hospitals, which made up more than 90 percent of all U.S. hospitals participating in the program in 1967, provided 40 hospital beds per 1,000 persons enrolled for hospital insurance in that year. The ratios of adult beds to the aged population shown for each geographic area in table 3.1.1 (and summarized in table C) ranged from 27 and 30 for Mississippi and Florida, respectively, to 68 for the District of Columbia, and up to 99 beds per 1,000 enrollees in Alaska, where there are relatively few persons aged 65 and over. The ratio for most States falls between 30 and 50 beds per 1,000 insured persons.

TABLE C.—Percentage distribution of adult beds in participating short-stay hospitals per 1,000 enrolled population, July 1, 1967.

Adult beds per 1,000 enrolled population	Number of States <sup>1</sup>	Percentage distribution
Total.....	52	100.0
20.0-29.9.....	2	3.8
30.0-39.9.....	18	34.6
40.0-49.9.....	25	48.2
50.0-59.9.....	4	7.7
60.0-69.9.....	2	3.8
70.0 or more.....	1	1.9

<sup>1</sup> Includes 50 States, District of Columbia, and Puerto Rico.

However, as noted previously, the effective number of beds available for use by Medicare enrollees depends, in part, on the size of the total population in the area and their utilization of short-stay hospitals.

<sup>3</sup> *Hospitals* (Journal of the American Hospital Association), Guide Issue, August 1, 1968.

*Bed size.*—In all areas, there were only 54 short-stay hospitals with more than 750 adult beds. None of these were privately owned; 26 were voluntary, while 28 were run by State or local governments. On the average, proprietary hospitals were substantially smaller than either voluntary or non-Federal government hospitals: 86 percent of the proprietary hospitals had fewer than 100 beds, compared with only half (49 percent) of the voluntary hospitals (table

TABLE D.—Number and percentage distribution of participating short-stay hospitals by control and size, all areas, 1967

Bed size	All hospitals	Total	Voluntary	Proprietary	State <sup>1</sup>	Local
Percentage distribution						
All areas.....	6,299	100.0	100.0	100.0	100.0	100.0
Less than 25 beds.....	690	11.0	6.2	22.5	17.1	13.8
25-49.....	1,621	25.6	19.4	37.4	7.8	35.5
50-99.....	1,559	24.8	23.4	26.2	21.1	27.5
100-149.....	774	12.3	14.8	7.6	17.1	8.9
150-199.....	480	7.6	10.2	3.3	7.8	4.3
200-249.....	332	5.3	7.2	2.4	5.1	2.6
250-299.....	228	3.6	5.5	0.3	3.7	1.4
300-399.....	306	4.8	7.1	0.3	8.3	2.2
400-499.....	144	2.3	3.3	—	3.7	1.2
500-749.....	111	1.8	2.2	—	3.7	1.5
750-999.....	37	0.6	0.6	—	3.2	0.5
1,000-1,999.....	13	0.2	0.1	—	1.4	0.4
2,000 or more.....	4	0.1	—	—	—	0.2

<sup>1</sup> Includes 3 Federal hospitals not shown in detail.

D). The median bed size of all voluntary hospitals is more than twice that of proprietary ones (table E). Short-stay hospitals run by State governments had the largest median bed size of all—112—twice as large as comparable hospitals under local public ownership.<sup>4</sup>

TABLE E.—Median bed size of participating short-stay hospitals, by control and region, 1967

Region	All hospitals	Voluntary	Proprietary	State <sup>1</sup>	Local
All areas.....	77	104	44	112	51
United States.....	78	104	43	138	52
Northeast.....	143	149	116	123	179
North Central.....	79	98	41	123	48
The South.....	63	94	38	275	56
The West.....	60	81	47	92	44

<sup>1</sup> Includes 3 Federal hospitals not shown in detail.

The median bed size of all short-stay hospitals was 77 beds; that of voluntary hospitals (accounting for over 56 percent of all short-stay facilities) was more than twice that of both proprietary and local hospitals (table E). Regional bed-size variations are even more pronounced: short-stay hospitals in the Northeast are substantially larger than all other regions (except for those run by State governments—which account for only 166 of the total of 6,198 hospitals in the 50 States and the District of Columbia). The predominance in the average size of Northeastern hospitals can be accounted for by the relatively large numbers of nonprofit and municipal hospitals in the larger urban areas of this region. These include many

of the very largest teaching hospitals in the country, which are located primarily in the Northeastern region.

Factors tending to depress the average size of short-stay hospitals outside the Northeastern region include the greater degree of ruralization in these other regions, as well as the large numbers of relatively small municipal and religious nonprofit hospitals which abound in the larger States which comprise the three other regions.

The distribution of hospital size also varies across the country. Table F shows the percentage of hospitals in each geographic division by bed size. The highest proportion of large hospitals is found in the Middle Atlantic States. About three-fourths of the short-stay hospitals in the West North Central, East South Central, West South Central, and Mountain States have fewer than 100 beds.

TABLE F.—Number and percentage distribution of participating short-stay hospitals, by bed size and division, 1967

Division	All hospitals	Bed size				
		Less than 100	100-249	250-499	500-749	750 or more
Number						
All areas.....	6,299	3,870	1,586	678	111	54
United States.....	6,198	3,791	1,570	672	111	54
New England.....	316	156	111	40	7	2
Middle Atlantic.....	711	206	309	149	29	18
East North Central.....	1,022	494	334	156	29	9
West North Central.....	877	649	150	60	13	5
South Atlantic.....	765	436	210	97	15	7
East South Central.....	461	342	81	32	3	3
West South Central.....	909	711	140	44	7	7
Mountain.....	376	288	62	25	1	—
Pacific.....	761	509	173	69	7	3
Percentage distribution						
All areas.....	100.0	61.3	25.1	10.8	1.8	1.0
United States.....	100.0	61.1	25.3	10.9	1.8	0.9
New England.....	100.0	49.4	35.1	12.7	2.2	0.6
Middle Atlantic.....	100.0	29.0	43.4	21.0	4.1	2.5
East North Central.....	100.0	48.3	32.8	15.2	2.8	0.9
West North Central.....	100.0	74.0	17.1	6.8	1.5	0.6
South Atlantic.....	100.0	56.9	27.5	12.7	2.0	0.9
East South Central.....	100.0	74.1	17.6	6.9	0.7	0.7
West South Central.....	100.0	78.2	15.4	4.8	0.8	0.8
Mountain.....	100.0	76.6	16.5	6.6	0.3	—
Pacific.....	100.0	66.9	22.7	9.1	0.9	0.4

*Facilities and services.*—Table 3.1.7 shows the number of participating hospitals reporting services and facilities available to their patients. For short-stay hospitals only, the percentages reporting each of the 22 identifiable facilities and services are shown in descending order in table G. Almost all short-stay hospitals report having five services—a clinical laboratory, diagnostic X-ray equipment, an operating room, electrocardiography, and an emergency room. Availability of the remaining 17 services and facilities generally varies according to the bed size of the hospital. As expected, the larger hospitals generally have the most comprehensive services.

There is considerable variation across geographical divisions in the percentages of services and facilities in participating short-stay hospitals (table H). Aside from the five services noted above as being almost

<sup>4</sup> "Local" hospitals are those run by cities, counties, joint city-county authorities, and hospital districts.



Commission. These accredited short-stay hospitals accounted for more than half of all short-stay hospitals (60 percent) and 85 percent of all adult beds in the United States. Table 3.1.9 shows that these proportions varied by region, with 94 percent of the beds in the Northeastern States in JCAH accredited hospitals, compared with 77 percent in the South.

*AOA accreditation.*—As with hospitals accredited by the Joint Commission, facilities accredited by the American Osteopathic Association were deemed to have met the standards established by regulation and embodied in the "Conditions of Participation," effective January 1, 1967, and thereafter.<sup>6</sup> During 1967, 199 accredited osteopathic hospitals were participating in the program, all but one were short-stay facilities. Table J shows that accredited osteopathic hospitals are located predominantly in States in the Middle West and the Southwest, and rarely on the eastern or western coasts.

TABLE J.—Number and percentage distribution of participating short-stay osteopathic hospitals and beds, by division, 1967

Division	Hospitals		Beds	
	Number	Percentage distribution	Number	Percentage distribution
United States.....	198	100.0	15,218	100.0
New England.....	5	2.5	392	2.6
Middle Atlantic.....	27	13.6	2,614	17.2
East North Central.....	54	27.3	6,463	42.4
West North Central.....	30	15.2	1,636	10.8
South Atlantic.....	18	9.1	885	5.8
East South Central.....	2	1.0	17	0.1
West South Central.....	45	22.7	2,088	13.7
Mountain.....	11	5.6	802	5.3
Pacific.....	6	3.0	321	2.1

*Training programs.*—The quality of care in a hospital is influenced in part by the presence of programs for training medical students. Hospitals applying for participation in the Medicare program reported the nature of their training programs (figure 1). From these replies, institutions have been classified into three categories (table 3.1.9). Nine percent of all short-stay hospitals, containing 26 percent of the adult short-stay beds, were affiliated with a major medical school.

<sup>6</sup> See "Registry of Accredited Osteopathic Institutions, 1970-71," American Osteopathic Association, 1970.

TABLE K.—Number and percentage distribution of participating short-stay hospitals and beds, by region and type of training program, United States, 1967

Training program	United States		Northeast		North Central		The South		The West	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Hospitals										
United States.....	6,198	100.0	1,027	16.6	1,899	30.6	2,135	34.5	1,137	18.3
Affiliated with medical school.....	570	100.0	175	30.7	180	31.6	153	26.8	62	10.9
Approved intern program.....	453	100.0	174	38.4	147	32.5	81	17.9	51	11.2
Approved resident program only.....	116	100.0	33	28.4	30	25.9	28	24.1	25	21.6
Beds										
United States.....	772,581	100.0	197,985	25.6	240,320	31.1	221,721	28.7	112,555	14.6
Affiliated with medical school.....	205,572	100.0	70,224	34.2	62,426	30.4	53,571	26.0	19,351	9.4
Approved intern program.....	129,215	100.0	49,844	38.6	42,175	32.6	22,938	17.8	14,258	11.0
Approved resident program only.....	23,625	100.0	5,932	25.1	4,894	20.7	6,771	28.7	6,028	25.5

Four hundred fifty-six hospitals not affiliated with a major medical school reported some type of intern program. In 116 additional hospitals there was a program for training residents only. These hospitals were, of course, not included in either of the first two categories.

The distribution of short-stay hospitals and adult beds, by class of training program, in the four geographic regions of the country, is shown in table K. The greatest relative concentration of participating short-stay hospitals in the United States affiliated with medical schools is in the North Central and Northeastern States, with 31.6 and 30.7 percent, respectively. Conversely, States in the West accounted for 11 percent of the affiliated hospitals.

## LONG-STAY HOSPITALS

Compared with short-stay facilities, hospitals in which the average patient stay is 30 days or more are fewer in number and, in general, of much larger size. There were 660 long-stay hospitals (almost 10 percent of all hospitals) participating in the Medicare program in 1967, but these included one-third of all the adult beds. Data for these institutions are shown in the general tables in the same detail as for short-stay hospitals.

*Tuberculosis hospitals.*—The average (mean) size of the 123 participating tuberculosis hospitals was 214 beds. The majority of these beds, and the highest ratio of beds with respect to the Medicare population, are found in the East North Central and South Atlantic States (table 3.1.3). Almost all are State or local hospitals. The facilities and services reported by these institutions relate to the type of care for which they are primarily organized. Among the more frequently reported services (not as commonly reported in short-stay hospitals) are medical social service and occupational therapy departments (table 3.1.7). Eighty percent of the tuberculosis beds are in JCAH accredited institutions, and almost one-fourth of the beds are in hospitals affiliated with medical schools (table 3.1.9).

*Psychiatric hospitals.*—There were over 300,000 beds in the 348 psychiatric hospitals participating in the Medicare program, or an average of 904 beds per

hospital. The Middle Atlantic, New England, and Pacific States had a far higher average ratio of psychiatric beds per 1,000 persons enrolled than the remainder of the country (table 3.1.1). Almost two-thirds of the psychiatric hospitals are under State or local control, and these include most of the larger institutions. Two of the 61 proprietary psychiatric hospitals had as many as 200 beds; half the voluntary hospitals had fewer than 100 beds (table 3.1.6). Facilities and services reported in psychiatric hospitals also were appropriate to the particular needs of the patients in these institutions—occupational therapy, medical social service, electroencephalograph, and pharmacy service were reported with frequencies greater than those for short-stay hospitals (table 3.1.7). Almost the same proportion of hospitals and beds were accredited by the JCAH as was true for the short-stay hospitals. Almost half the psychiatric beds were in institutions affiliated with medical schools with an additional one-fourth of the beds in hospitals with resident programs only.

*Other long-stay hospitals.*—These institutions comprised 3 percent of all participating hospitals and contained 4 percent of the adult beds. Only 4 percent of these beds were in proprietary hospitals, an additional 23 percent in voluntary hospitals, and the remainder in government hospitals (table 3.1.5). There are eight long-stay beds per 1,000 enrolled population in the New England States, the highest ratio of any division for this class of hospital (table 3.1.1). For the country as a whole, over half the long-stay hospitals, containing more than two-thirds of the adult beds, were accredited by the JCAH. Over one-fourth of the beds were in hospitals affiliated with medical schools.

TABLE L.—Number and percentage distribution of participating long-stay hospitals, by type of hospital and bed size, all areas, 1967

Bed size	All hospitals	Tuberculosis	Psychiatric	Other long-stay
Number				
All areas.....	660	123	348	189
Less than 25 beds.....	19	3	6	10
25-49.....	73	9	30	34
50-99.....	140	30	64	46
100-149.....	87	26	37	24
150-199.....	52	12	25	15
200-249.....	37	8	16	13
250-299.....	25	5	11	9
300-399.....	37	12	14	11
400-499.....	25	5	12	8
500-749.....	43	9	23	11
750-999.....	18	2	13	3
1,000-1,999.....	50	2	43	5
2,000 or more.....	54	—	54	—
Percentage distribution				
All areas.....	100.0	100.0	100.0	100.0
Less than 25 beds.....	2.9	2.4	1.7	5.3
25-49.....	11.1	7.3	8.6	18.0
50-99.....	21.1	24.4	18.5	24.3
100-149.....	13.2	21.1	10.6	12.7
150-199.....	7.9	9.8	7.2	7.9
200-249.....	5.6	6.5	4.6	6.9
250-299.....	3.8	4.1	3.2	4.8
300-399.....	5.6	9.8	4.0	5.8
400-499.....	3.8	4.1	3.4	4.2
500-749.....	6.5	7.3	6.6	5.8
750-999.....	2.7	1.6	3.7	1.6
1,000-1,999.....	7.6	1.6	12.4	2.7
2,000 or more.....	8.2	—	15.5	—

*Christian Science sanatoriums.*—Christian Science sanatoriums that are operated or listed and certified by the First Church of Christ Scientist, in Boston, may participate in the program as both “hospitals” and “extended care facilities.” Payments to Christian Science sanatoriums cover costs of services ordinarily furnished by these sanatoriums that are comparable to those for which payment is made to hospitals in the sense that services in a sanatorium are a substitute for, and not in addition to, medical services that might be furnished a person if his religious beliefs were not contrary to the use of the usual facilities. By the end of 1967, 19 such sanatoriums, distributed in 15 States, were participating as shown below. Data on these institutions are not included in either the general or text tables covering participating hospitals.

State	Number of facilities
Total.....	19
California.....	3
Colorado.....	1
Florida.....	1
Illinois.....	1
Massachusetts.....	1
Michigan.....	1
Missouri.....	2
New Jersey.....	1
New York.....	1
Ohio.....	1
Oregon.....	1
Pennsylvania.....	1
Texas.....	1
Washington.....	2
Wisconsin.....	1

## Conditions of Participation

The following material is excerpted from the Code of Federal Regulations, Title 20, Chapter III, “Conditions of Participation: Hospitals” (HIR-10), Social Security Administration.

*General hospitals.*—In order to participate in the hospital insurance program, hospitals must satisfy requirements specified in the law and in regulations issued by the Secretary of Health, Education, and Welfare. By law, a hospital is defined as an institution primarily engaged in providing diagnostic, therapeutic, or rehabilitation services by or under the supervision of physicians to inpatients. The hospital must maintain clinical records for all patients, have by-laws in effect for its medical staff, require every patient to be under the care of a physician, and provide 24-hour nursing service, rendered or supervised by a registered professional nurse, with a licensed practical nurse or registered professional nurse on duty at all times. An acceptable hospital utilization review plan must be in effect, and the hospital must be licensed (or meet licensing standards) pursuant to applicable State or local law. In addition, the Secretary of Health, Education, and Welfare may prescribe other requirements that he deems necessary to protect the health and safety of the institution’s patients.

Other requirements “necessary for health and safety” that are established by the Secretary may not be higher than those prescribed by the Joint Commis-

sion on Accreditation of Hospitals. However, such requirements may be varied for different areas or different types of institutions. In addition, higher requirements than those prescribed by JCAH may be established by the Secretary at the request of a State. In all instances, the requirements under Medicare must be equivalent to those established by the State for its medical assistance programs.<sup>7</sup>

*Special certification.*—Where denial of participation to hospitals seriously limits the access of beneficiaries to needed services because of such factors as isolated location or the absence of sufficient facilities in an area, the hospital may, upon recommendation of the State agency, be approved as a provider of services. Such approval (also termed “limited access” certifications) are granted only where the hospital has no deficiencies that would jeopardize the health and safety of patients, and is making the best use of existing resources to improve its services. This special certification is limited to general hospitals. Each case is decided on its individual merits, and while the degree and extent of compliance will vary, the facility must meet the original statutory conditions spelled out in the Social Security Amendments of 1965, Section 1861(e)(1)–(7), in addition to any other such requirements as the Secretary of Health, Education, and Welfare may find necessary.

*Nonparticipating hospitals for emergency use.*—Under the hospital insurance program, payments may also be made for emergency care provided to Medicare beneficiaries by certain nonparticipating hospitals including Federal hospitals. However, such institutions must meet all of the statutory provisions for participating hospitals except for the requirement for a functioning utilization review plan. In addition, such institutions do not have to satisfy other requirements promulgated by the Secretary for participating hospitals to protect the health and safety of their patients. The payment of benefits for emergency hospital diagnostic services or inpatient care is permitted until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution. To be paid under the program for emergency services, nonparticipating hospitals, like participating hospitals, must agree not to charge the patient amounts (except the deductibles) in addition to the program’s payments for covered services.

*Christian Science sanatoriums.*—Christian Science sanatoriums that are operated or listed and certified by the First Church of Christ Scientist, in Boston, may participate in the program as “hospitals.” Payments to Christian Science sanatoriums cover costs of services ordinarily furnished by these sanatoriums that are comparable to those for which payment is made to hospitals in the sense that services in a sanatorium

are a substitute for, and not an addition to, medical services that might be furnished a person if his religious beliefs were not contrary to the use of the usual facilities.

*Tuberculosis and psychiatric hospitals.*—A tuberculosis hospital is one that is primarily engaged in providing medical services for the diagnosis or treatment of the disease, by or under the supervision of a physician. Similarly, a psychiatric hospital is one primarily engaged in providing psychiatric services for the diagnosis and treatment of the mentally ill. To participate under Medicare such hospitals must meet the conditions of participation for other hospitals established in the law or by the Secretary in regulations. They must also meet certain additional special requirements. Tuberculosis and psychiatric hospitals must be accredited by the Joint Commission on Accreditation of Hospitals. Such hospitals must maintain clinical records on all patients. They must also maintain other records that enable the Secretary to determine the degree and intensity of treatment furnished to beneficiaries. Tuberculosis and psychiatric hospitals must also meet such staffing requirements as the Secretary finds necessary for the institution to carry out an active treatment program.

Tuberculosis and psychiatric hospitals may provide both active and custodial care. The special requirements relating to records and staffing, described above, are intended to help assure that the Medicare program does not pay for custodial care in either tuberculosis or psychiatric hospitals. Where such hospitals provide both active and custodial care, the distinct part, that is, the specific wing or ward, that provides active care may participate in the program if it meets the records and staffing conditions noted above and the entire facility is accredited by the Joint Commission on Accreditation of Hospitals. If the entire facility is not accredited, the distinct part providing active treatment may still participate if the latter meets conditions equivalent to the requirements for JCAH accreditation.

*Utilization review plan.*—The purpose of utilization review is to assure that patients are in the health facility appropriate to the care and services they require. To be acceptable, a hospital’s utilization review plan must apply to all patients who are Medicare beneficiaries. It must provide for (1) the review, on a sample or other basis, of admissions to the hospital, the length of stay, and the professional services (including drugs and biologicals) furnished, with respect to the medical necessity of the services, and the most efficient use of available health facilities and services; and (2) for the review of each case of continuous extended duration. The definition of what constitutes an “extended duration” case is left to each hospital. Most hospitals have defined them as cases with stays of 30 days or more.

The review should be made by either a staff committee of the institution composed of two or more

<sup>7</sup> Standards established by the accrediting agency for osteopathic hospitals, the American Osteopathic Association, were deemed equivalent to those accorded to the Joint Commission on Accreditation of Hospitals. The policy first became operative, by regulation, during calendar year 1967.

physicians (with or without participation of other professional personnel), or a group from outside the institution similarly composed and established jointly by the local medical society and some or all of the hospitals in the locality, or where such a group does not exist to serve the institution, it is established in such a manner as may be approved by the Secretary.

*Title VI of the Civil Rights Act.*—In addition to meeting the quality standards established under the health insurance legislation, hospitals wishing to participate in the Medicare program must be in compliance with Title VI of the Civil Rights Act of 1964. In its application to Medicare, the Act requires that hospitals and other institutions participating in the program must provide access to their services and facilities without regard to the race, color, or national origin of a patient; that ancillary services and facilities be equally available to all people; and that the staff be recruited and employed in a nondiscriminatory manner. To meet these requirements an institution must engage in no discrimination, separation, or other distinction on the basis of race, color, or national origin in providing services, facilities, or any other activities that influence the admission, care, or treatment of patients.

*Certification process.*—Hospitals that wish to participate under the Medicare program must apply for and establish their eligibility to do so. The hospital must demonstrate that it meets the conditions of participation described above.

Title XVIII of the Social Security Act provides that State agencies, primarily health departments, operating under agreement with the Secretary, will determine whether prospective hospitals meet the conditions of participation. The State agencies certify to the Department of Health, Education, and Welfare institutions that meet these conditions. A hospital that is found to meet the specific statutory requirements and to be in substantial compliance with additional conditions prescribed in regulations may sign an agreement with the SSA to become a participating hospital.

In carrying out their responsibilities under the health insurance program, the State agencies conduct field surveys of hospitals to determine the extent to which these facilities are in substantial compliance with the applicable conditions of participation; undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions; provide consultative services to facilities experiencing difficulties in meeting the participation requirements; identify nonparticipating hospitals that could be reimbursed under the program for emergency services; and coordinate activities under the health insurance program with activities conducted under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform under the program, including related costs of administrative overhead and staff.

The regulations provide that the initial certification of hospitals found to be in substantial compliance is for a period of 2 years. If deficiencies in one or more of the conditions are found on initial survey, a resurvey must be made by the State agency within 18 months or earlier, depending on the nature of the deficiencies.

Hospitals with special certifications ("limited access") are resurveyed within 12 months or sooner if the State agency believes it appropriate. If, on resurvey, it is determined that the provider has not corrected serious deficiencies and that the factor of limited access no longer applies, the provider's participation is terminated.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals were deemed to meet all the conditions for participation, except for that relating to the utilization review plan.<sup>8</sup> Hospitals are certified to participate in Medicare if they are found to be in substantial compliance with the conditions of participation. In determining whether a hospital complies substantially with the conditions of participation, State agencies use a series of standards supplemented by explanatory factors for each prescribed condition as set forth in regulations of the Department of Health, Education, and Welfare. Application of these standards and factors requires a thorough evaluation of the degree to which operation of the hospital demonstrates adequate performance of the activities and functions embodied in the conditions.

Those hospitals with deficiencies in one or more of the conditions of participation may nevertheless be found to be in substantial compliance and certified for participation if the deficiency: (1) does not involve failure to meet a specific statutory requirement, (2) does not interfere with adequate patient care, (3) does not represent a hazard to patient health or safety, and (4) is one which the institution is making reasonable plans and efforts to correct. Consultative services were made available by the State agencies to help providers complete their plans for correcting all deficiencies.

If a provider is judged not to be in compliance, or after a period of participation is no longer in compliance with the conditions of participation, the State agency informs the Social Security Administration of this fact. The Social Security Administration in turn (under powers delegated by the Secretary of Health, Education, and Welfare) acts on the State agency's finding—terminating the provider's contract, if appropriate. If the provider disagrees with the Administration's decision, a review of the decision may be requested, at which time an administrative review of SSA's determination is accomplished.

An agreement may be terminated by either the provider of services or the Secretary of Health, Edu-

<sup>8</sup> Hospitals accredited by the American Osteopathic Association were first accorded comparable status during calendar year 1967.

cation, and Welfare. Beneficiaries are protected from an abrupt termination of an agreement by a provider through a requirement that notice must be given by the provider to the Secretary and to the public. The length of time between the notice and the point at which the termination becomes effective is specified in regulations, but the length of time cannot be longer than 6 months.

The Secretary may terminate an agreement only after reasonable notice and only if the provider (a) does not comply with the provisions of the agreement or of the law and regulation, (b) is no longer eligible to participate, or (c) fails to provide data needed to determine what benefit amounts are payable or refuses access to financial records for verification of bills. The Secretary is required to give the provider reasonable notice and an opportunity for a hearing before making a final determination that the provider does not qualify to participate under the program or before terminating an agreement. The final administrative decision is subject to judicial review.

*Level of certification.*—Hospitals can be accepted for complete participation in the program at the following levels of certification :

1. With no significant deficiencies,
2. With correctible deficiencies,
3. Special certification.

Almost 65 percent of all short-stay hospitals had no significant deficiencies, with an additional 26 percent having correctible deficiencies (table M). Significantly greater proportions of the tuberculosis and other long-stay hospitals were found to have no significant deficiencies. Psychiatric institutions had the highest proportion with correctible deficiencies—just over 42 percent.

TABLE M.—Number and percentage distribution of participating hospitals, by level of certification and type of hospital, all areas, 1967

Level of certification	All hospitals	Short-stay hospitals	Long-stay hospitals		
			Tuberculosis	Psychiatric	Other
Number					
All areas-----	6,959	6,299	123	348	189
No significant deficiencies-----	4,578	4,129	94	219	136
Correctible deficiencies-----	1,755	1,544	29	129	53
Special certification-----	626	626	—	—	—
Percentage distribution					
All areas-----	100.0	100.0	100.0	100.0	100.0
No significant deficiencies-----	65.8	65.6	76.4	62.9	72.0
Correctible deficiencies-----	25.2	24.5	23.6	37.1	28.0
Special certification-----	9.0	9.9	—	—	—

*Hospitals with special certification.*—A total of 617 short-stay hospitals, or 8.9 percent of all participating hospitals were accorded special certification (table N). "Special certification" is defined on page xv.

There were great variations in their distribution among the geographic divisions; more than one-third (36.8 percent) of the hospitals in the West South Central States had special certifications, compared to less than 1 percent in the New England States. The States in the East South Central, West South Central, and Mountain divisions accounted for almost 80 percent of all hospitals in this category. Texas alone accounted for almost 40 percent of all specially-certified hospitals.

TABLE N.—Number of participating hospitals and percent with special certification, by division and State, 1967

Division and State	All hospitals	Percent with special certification
All areas.....	6,959	8.9
United States.....	6,849	8.8
New England.....	387	0.5
Maine.....	63	1.6
New Hampshire.....	35	2.9
Vermont.....	26	—
Massachusetts.....	190	—
Rhode Island.....	22	—
Connecticut.....	51	—
Middle Atlantic.....	825	2.7
New York.....	408	3.7
New Jersey.....	123	5.7
Pennsylvania.....	294	—
East North Central.....	1,183	1.3
Ohio.....	270	1.9
Indiana.....	137	—
Illinois.....	302	2.0
Michigan.....	285	1.1
Wisconsin.....	189	0.5
West North Central.....	927	3.8
Minnesota.....	199	0.5
Iowa.....	148	2.7
Missouri.....	171	9.9
North Dakota.....	64	9.4
South Dakota.....	66	1.5
Nebraska.....	109	5.5
Kansas.....	170	—
South Atlantic.....	838	4.3
Delaware.....	9	—
Maryland.....	61	1.6
District of Columbia.....	14	—
Virginia.....	121	—
West Virginia.....	86	—
North Carolina.....	153	5.9
South Carolina.....	72	2.8
Georgia.....	141	14.9
Florida.....	181	1.7
East South Central.....	490	14.3
Kentucky.....	133	—
Tennessee.....	156	17.9
Alabama.....	118	15.3
Mississippi.....	83	28.9
West South Central.....	945	36.8
Arkansas.....	108	25.0
Louisiana.....	120	27.5
Oklahoma.....	154	36.4
Texas.....	563	41.2
Mountain.....	403	15.1
Montana.....	67	7.5
Idaho.....	50	36.0
Wyoming.....	31	3.2
Colorado.....	91	18.7
New Mexico.....	47	14.9
Arizona.....	61	4.9
Utah.....	36	19.4
Nevada.....	20	15.0
Pacific.....	851	1.8
Washington.....	120	—
Oregon.....	88	—
California.....	598	1.5
Alaska.....	18	5.6
Hawaii.....	27	18.5
Outlying areas.....	110	11.8
Guam.....	1	—
Puerto Rico.....	103	12.6
Virgin Islands.....	5	—
Other outlying areas.....	1	—

## Nonparticipating Hospitals

A NONPARTICIPATING hospital<sup>1</sup> is "one which does not have an agreement to participate whether or not it meets other requirements for participation. Such a hospital, however, may receive payment for inpatient hospital services or outpatient hospital diagnostic services furnished by it, or by others under arrangements with it, under the following conditions:

- "a. the services *must* be emergency services;
- "b. they must be covered under *hospital* insurance;
- "c. the hospital must meet the requirements of the definition of a hospital (see page xx), psychiatric hospital, or tuberculosis hospital, except for the utilization review plan and the health and safety conditions prescribed by the Secretary of Health, Education, and Welfare; and
- "d. it must agree *on an individual basis* not to charge any patient or other person for items or services covered by hospital insurance except deductibles and coinsurance amounts; and return any money incorrectly collected."

There are two bases for a hospital's eligibility to provide emergency services: an "emergency" hospital is one that agrees to the above conditions and is not federally owned; and a Federal hospital otherwise meeting the definition of a hospital. A number of hospitals that were not certified under the program (and not included in the general tables) were approved to render reimbursable inpatient services if the admission were emergency in nature. "Emergency" services were defined as "outpatient hospital diagnostic services, and inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitates the use of the most accessible hospital available which is equipped to furnish such services."

The number of hospitals approved to be reimbursed for emergency services is shown in table 0. There were 799 non-Federal emergency hospitals, with 105,513 beds, active during 1967. The South Atlantic, East South Central, and West South Central States accounted for almost 60 percent of all emergency hospitals, and 70 percent of the beds in these facilities. While many emergency hospitals comprise facilities such as pediatric, maternity and other special hospitals not routinely set up to care for geriatric patients, this was not necessarily so in many States in the South during 1967. Failure to comply with certain civil rights guidelines prevented many southern short-stay hospitals from participating fully until 1968 and thereafter.

Federal hospitals, by statute, cannot participate in the Medicare program unless the Secretary of Health, Education, and Welfare finds that such hospitals serve the community as a whole. During 1967, three Federal hospitals were designated as community facilities—two in the District of Columbia, and one in American Samoa. All other Federal hospitals that met the definition of a "hospital" under the 1965 amendments to the Social Security Act were approved to render "emergency" services, also as defined in the 1965 amendments. The numbers of Federal facilities, and their beds by State, are shown in table P.

The Guide Issue of *Hospitals* (August 1, 1968), published by the American Hospital Association, shows that there were 416 Federal hospitals in the United States at the end of 1967. The present report lists 409 Federal hospitals<sup>2</sup> eligible for emergency services, and three participating fully during the same period. This difference occurs because a minute number (4) of the Federal hospitals listed in the Guide Issue of *Hospitals* are outpatient facilities only, or otherwise do not meet the statutory definition of a "hospital," which definition does not agree precisely with that used by the AHA in its annual survey.

<sup>1</sup> See Section 202, "Hospital Emergency Services," *Hospital Manual* (HIM-10), Social Security Administration.

<sup>2</sup> Excludes three Federal hospitals in Puerto Rico.

TABLE O.—Number of emergency hospitals and beds, by division and State, 1967

Division and State	Hospitals	Beds
All areas.....	799	105,513
United States.....	776	104,583
New England.....	22	2,590
Maine.....	5	1,369
New Hampshire.....	1	128
Vermont.....	3	71
Massachusetts.....	11	658
Rhode Island.....	1	50
Connecticut.....	1	314
Middle Atlantic.....	93	8,902
New York.....	39	3,615
New Jersey.....	20	2,259
Pennsylvania.....	34	3,028
East North Central.....	81	10,525
Ohio.....	21	3,825
Indiana.....	5	260
Illinois.....	23	3,241
Michigan.....	19	1,431
Wisconsin.....	13	1,768
West North Central.....	25	2,069
Minnesota.....	1	8
Iowa.....	11	1,148
Missouri.....	5	697
North Dakota.....	2	42
South Dakota.....	—	—
Nebraska.....	6	174
Kansas.....	—	—
South Atlantic.....	159	26,097
Delaware.....	1	60
Maryland.....	9	2,176
District of Columbia.....	3	281
Virginia.....	26	9,388
West Virginia.....	13	5,319
North Carolina.....	20	1,211
South Carolina.....	17	2,060
Georgia.....	41	2,258
Florida.....	29	3,344
East South Central.....	151	30,647
Kentucky.....	21	3,246
Tennessee.....	29	9,207
Alabama.....	37	11,978
Mississippi.....	64	6,216
West South Central.....	149	16,712
Arkansas.....	10	1,446
Louisiana.....	61	9,403
Oklahoma.....	17	2,703
Texas.....	61	3,160
Mountain.....	38	3,617
Montana.....	6	169
Idaho.....	3	1,642
Wyoming.....	3	61
Colorado.....	4	63
New Mexico.....	7	975
Arizona.....	11	498
Utah.....	4	209
Nevada.....	—	—
Pacific.....	58	3,424
Washington.....	12	384
Oregon.....	4	91
California.....	38	2,570
Alaska.....	—	—
Hawaii.....	4	379
Outlying areas.....	23	930
Guam.....	—	—
Puerto Rico.....	23	930
Virgin Islands.....	—	—
Other outlying areas.....	—	—

TABLE P.—Number of Federal<sup>1</sup> hospitals and beds, by division and State, 1967

Division and State	Hospitals	Beds
All areas.....	412	166,935
United States.....	409	166,495
New England.....	22	10,725
Maine.....	3	929
New Hampshire.....	2	379
Vermont.....	1	188
Massachusetts.....	9	5,075
Rhode Island.....	3	783
Connecticut.....	4	3,371
Middle Atlantic.....	35	25,985
New York.....	17	14,542
New Jersey.....	5	3,524
Pennsylvania.....	13	7,919
East North Central.....	42	26,629
Ohio.....	7	3,639
Indiana.....	6	2,734
Illinois.....	10	9,377
Michigan.....	15	7,586
Wisconsin.....	4	3,293
West North Central.....	35	13,763
Minnesota.....	2	2,393
Iowa.....	3	2,320
Missouri.....	9	3,591
North Dakota.....	3	394
South Dakota.....	5	1,412
Nebraska.....	5	1,082
Kansas.....	8	2,571
South Atlantic.....	74	26,158
Delaware.....	2	370
Maryland.....	13	4,751
District of Columbia.....	1	1,485
Virginia.....	11	4,875
West Virginia.....	5	1,461
North Carolina.....	9	4,014
South Carolina.....	6	2,194
Georgia.....	13	3,819
Florida.....	14	3,189
East South Central.....	28	13,775
Kentucky.....	6	3,478
Tennessee.....	6	3,371
Alabama.....	10	4,928
Mississippi.....	6	1,998
West South Central.....	57	17,878
Arkansas.....	5	2,862
Louisiana.....	8	2,490
Oklahoma.....	12	1,648
Texas.....	32	10,878
Mountain.....	52	8,069
Montana.....	7	431
Idaho.....	2	243
Wyoming.....	3	875
Colorado.....	6	2,679
New Mexico.....	12	1,294
Arizona.....	17	1,644
Utah.....	1	578
Nevada.....	4	325
Pacific.....	64	23,513
Washington.....	13	3,524
Oregon.....	3	1,260
California.....	35	16,530
Alaska.....	12	1,199
Hawaii.....	1	1,000
Outlying areas.....	3	440
Guam.....	—	—
Puerto Rico.....	3	440
Virgin Islands.....	—	—
Other outlying areas.....	—	—

<sup>1</sup> Excludes Federal hospitals participating as community hospitals.

## Source of the Data

TO BE reimbursed for services provided, a hospital must apply for and be accepted for participation in the hospital insurance program. Data included on the applications ("Hospital Request to Establish Eligibility," Form SSA-1514, figure 1) used by hospitals to request certification for participation are recorded in the central provider records and are updated as facilities are recertified periodically, as new ones apply for participation, or as some leave the program. Upon receipt of these forms in the Social Security Administration's central office, information provided by the hospital describing its characteristics is entered into a Master Provider of Services file. All data shown in the general and text tables of this report are compiled from the information shown on the "Hospital Request to Establish Eligibility" (Form SSA-1514, figure 1) and on the "Certification and Transmittal" (Form SSA-1539, figure 2). The latter form is processed and transmitted by the contracting State agency upon receipt of the original provider application form. The information provided by each hospital includes such items as the State and county in which the institution is located; number of adult beds; type of control; major types of services provided; accreditation status, medical school affiliation, and approved training programs; and staff characteristics, including the number of physicians, registered nurses, qualified speech therapists, licensed practical nurses, home health aids, and other skilled medical care personnel.

When the information in the Master Provider of Services file is combined with utilization data, it serves to relate the characteristics of facilities that provide care to the type and cost of service used by the aged.

The eligibility forms were completed by all applicant hospitals in accordance with instructions furnished by the Social Security Administration.<sup>1</sup> For some items on the form, familiarity by these respondents with the well-established definitions promulgated by the American Hospital Association was assumed. These definitions and explanations are shown below.<sup>2</sup>

<sup>1</sup> See the Code of Federal Regulations, Title 20, Chapter III, Part 405, "Conditions of Participation: Hospitals" (HIR-10), Social Security Administration.

<sup>2</sup> See "Instructions for Completing Annual Survey of Hospitals Registered by the American Hospital Association, 1969." *Hospitals* (Journal of the American Hospital Association), Guide Issue, August 1, 1970.

### TYPES OF HOSPITALS

*Short-stay general and special hospitals.*—Includes only those where the average length of stay has been, or is, under 30 days.

*Long-stay general and special hospitals.*—Includes those hospitals where the average length of stay is 30 days or more. Such hospitals may be general, chronic disease, or special long-stay hospitals. Excluded are those hospitals primarily for the care and treatment of tuberculosis or mental diseases.

*Tuberculosis hospitals.*—Includes only those hospitals primarily engaged in providing medical services for the diagnosis and treatment of tuberculosis by or under the supervision of a physician.

*Psychiatric hospitals.*—Includes only those hospitals primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons by or under the supervision of a physician.

*Christian Science sanatoriums.*—May be considered "hospitals" in respect to such items and services ordinarily furnished by the institution or additionally stipulated by the Secretary in regulations, if operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts. These institutions are not included in the general tables.

*"Special certification" facility.*—Where, by reason of factors such as isolated location or absence of sufficient hospitals in an area, the denial of eligibility of a provider to participate would seriously limit the access of beneficiaries to participating facilities, an institution may, upon recommendation by the State agency, be approved as a provider of services. Such approvals are granted only where there are no deficiencies of such character and severity as to jeopardize the health and safety of Medicare patients. Providers receiving such special approvals furnish information periodically to the State agency to show improvement toward an acceptable level of participation.

*Facility for emergency services.*—A beneficiary may use a nonparticipating hospital for emergency services where these services are defined as "outpatient hospital diagnostic services and inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health

Figure 1.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

## HOSPITAL REQUEST TO ESTABLISH ELIGIBILITY IN THE HEALTH INSURANCE FOR THE AGED PROGRAM

All hospitals desiring to establish their eligibility in the health insurance program should complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Administration district office.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals will be considered to meet all of the Conditions for Participation in the program, except that of having a utilization review plan.

SUBMISSION OF THIS FORM AND ESTABLISHING ELIGIBILITY DOES NOT OBLIGATE A HOSPITAL TO PARTICIPATE. AN AGREEMENT WILL BE MADE AVAILABLE BY THE SOCIAL SECURITY ADMINISTRATION AT A LATER DATE TO HOSPITALS WHO HAVE ESTABLISHED ELIGIBILITY. THERE IS NO COMMITMENT UNTIL THE AGREEMENT IS SIGNED.

Form approved,  
Budget Bureau No. 72-R717

DO NOT WRITE IN THIS SPACE			
ID			
S/C			
SMSA			
DO			
DATE CERTIFIED			
CERTIFICATION			

  

<b>I. Identifying Information</b>	NAME OF HOSPITAL		STREET ADDRESS		
	CITY, COUNTY, AND STATE		ZIP CODE	TELEPHONE NUMBER (Including area code)	
	NAME OF CHIEF ADMINISTRATIVE OFFICER		TITLE		
	NAME AND ADDRESS OF PARENT INSTITUTION (If applicable)				
<b>II. Licensure</b>	1 <input type="checkbox"/> Licensed or approved as a hospital by a state or local Government Agency NAME OF AGENCY		<div style="text-align: center;">LICENSE EFFECTIVE</div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">BEGINNING DATE</div> <div style="width: 45%;">THRU DATE</div> </div>		2 <input type="checkbox"/> No license or approval required
<b>III. JCAH Accreditation</b>	1 <input type="checkbox"/> THREE YEAR		2 <input type="checkbox"/> ONE YEAR		
	BEGINNING DATE	THRU DATE	BEGINNING DATE	THRU DATE	
	3 <input type="checkbox"/> NOT ACCREDITED    a. <input type="checkbox"/> Accreditation Pending    b. <input type="checkbox"/> Refused <input type="checkbox"/> Never Applied				
<b>IV. Utilization Review Plan</b>	A. Does the hospital have a Utilization Review Plan in effect at present?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No				
	B. If "Yes," Utilization Review to be made by:				
	<div style="display: flex; justify-content: space-between;"> <div>1 <input type="checkbox"/> Committee(s) of Hospital Medical Staff</div> <div>2 <input type="checkbox"/> Group outside the Hospital established by Local Medical Society</div> <div>3 <input type="checkbox"/> Other</div> </div>				
PLEASE ATTACH A COPY OR TENTATIVE DESCRIPTION OF YOUR UTILIZATION REVIEW PLAN, IF AVAILABLE.					
<b>V. Nursing</b>	Does the hospital provide 24-hour nursing service rendered or supervised by a registered professional nurse and is a licensed practical nurse or a registered professional nurse on duty at all times?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No				
<b>VI. By-Laws</b>	Does the hospital have by-laws in effect with respect to its staff of physicians?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No				

<b>VII.</b> Type of Hospital (Check one that most accurately describes)	<b>ITEMS VII THRU XIII ARE FOR STATISTICAL PURPOSES</b>											
	1 <input type="checkbox"/> General—Short Term	4 <input type="checkbox"/> Psychiatric	7 <input type="checkbox"/> Specialty—Long Term									
	2 <input type="checkbox"/> General—Long Term	5 <input type="checkbox"/> Chronic Disease	8 <input type="checkbox"/> Other (Specify) _____									
	3 <input type="checkbox"/> Tuberculosis	6 <input type="checkbox"/> Specialty—Short Term										
<b>VIII.</b> Type of Control (Check one)	<table style="width: 100%; border: none;"> <tr> <td style="width: 40%; border: none;"> <b>Voluntary Non-Profit</b>            1 <input type="checkbox"/> Church            2 <input type="checkbox"/> Other (Specify) _____         </td> <td style="width: 20%; border: none; text-align: center;"> <b>Government (Non-Federal)</b>            4 <input type="checkbox"/> State            5 <input type="checkbox"/> County            6 <input type="checkbox"/> City            7 <input type="checkbox"/> City—County            8 <input type="checkbox"/> Hospital District         </td> </tr> <tr> <td style="border: none;"> <b>Proprietary</b> 3 <input type="checkbox"/> </td> <td style="border: none; text-align: center;"> <b>Government (Federal)</b> 9 <input type="checkbox"/> Specify Agency _____         </td> </tr> </table>			<b>Voluntary Non-Profit</b> 1 <input type="checkbox"/> Church 2 <input type="checkbox"/> Other (Specify) _____	<b>Government (Non-Federal)</b> 4 <input type="checkbox"/> State 5 <input type="checkbox"/> County 6 <input type="checkbox"/> City 7 <input type="checkbox"/> City—County 8 <input type="checkbox"/> Hospital District	<b>Proprietary</b> 3 <input type="checkbox"/>	<b>Government (Federal)</b> 9 <input type="checkbox"/> Specify Agency _____					
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<b>Proprietary</b> 3 <input type="checkbox"/>	<b>Government (Federal)</b> 9 <input type="checkbox"/> Specify Agency _____											
<b>IX.</b> Facilities and Services Available on the Premises (Check all applicable)	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">           01 <input type="checkbox"/> Blood Bank            02 <input type="checkbox"/> Clinical Laboratory            03 <input type="checkbox"/> Pathology Laboratory            04 <input type="checkbox"/> Electrocardiograph            05 <input type="checkbox"/> Electroencephalograph            06 <input type="checkbox"/> Pharmacy            07 <input type="checkbox"/> Occupational Therapy Dept.            08 <input type="checkbox"/> Physical Therapy Dept.            09 <input type="checkbox"/> Intensive Care Unit         </td> <td style="width: 33%; border: none;">           10 <input type="checkbox"/> Organized Outpatient Dept.            11 <input type="checkbox"/> Emergency Department            12 <input type="checkbox"/> Home Care Program            13 <input type="checkbox"/> Operating Room            14 <input type="checkbox"/> Post-Operative Recovery Room            15 <input type="checkbox"/> Medical Social Service Dept.            16 <input type="checkbox"/> X-Ray, Diagnostic            17 <input type="checkbox"/> X-Ray, Therapeutic            18 <input type="checkbox"/> Radioactive Isotope Facility         </td> <td style="width: 33%; border: none;">           19 <input type="checkbox"/> Psychiatric Inpatient Care Unit            20 <input type="checkbox"/> Cobalt and Radium Therapy            21 <input type="checkbox"/> Rehabilitation Unit            22 <input type="checkbox"/> Extended Care Unit            23 <input type="checkbox"/> Other (Specify) _____         </td> </tr> </table>			01 <input type="checkbox"/> Blood Bank 02 <input type="checkbox"/> Clinical Laboratory 03 <input type="checkbox"/> Pathology Laboratory 04 <input type="checkbox"/> Electrocardiograph 05 <input type="checkbox"/> Electroencephalograph 06 <input type="checkbox"/> Pharmacy 07 <input type="checkbox"/> Occupational Therapy Dept. 08 <input type="checkbox"/> Physical Therapy Dept. 09 <input type="checkbox"/> Intensive Care Unit	10 <input type="checkbox"/> Organized Outpatient Dept. 11 <input type="checkbox"/> Emergency Department 12 <input type="checkbox"/> Home Care Program 13 <input type="checkbox"/> Operating Room 14 <input type="checkbox"/> Post-Operative Recovery Room 15 <input type="checkbox"/> Medical Social Service Dept. 16 <input type="checkbox"/> X-Ray, Diagnostic 17 <input type="checkbox"/> X-Ray, Therapeutic 18 <input type="checkbox"/> Radioactive Isotope Facility	19 <input type="checkbox"/> Psychiatric Inpatient Care Unit 20 <input type="checkbox"/> Cobalt and Radium Therapy 21 <input type="checkbox"/> Rehabilitation Unit 22 <input type="checkbox"/> Extended Care Unit 23 <input type="checkbox"/> Other (Specify) _____						
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<b>X.</b> Bed Capacity	TOTAL ADULT BEDS _____											
<b>XI.</b> Number of Medical Staff Members	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">A. ACTIVE</td> <td style="width: 33%; border: none;">B. CONSULTING</td> <td style="width: 33%; border: none;">C. HONORARY</td> </tr> <tr> <td style="border: none;">D. ASSOCIATE</td> <td style="border: none;">E. COURTESY</td> <td style="border: none;">F. INTERNS-IN-TRAINING</td> </tr> <tr> <td style="border: none;">G. RESIDENTS-IN-TRAINING</td> <td colspan="2" style="border: none;">H. OTHER</td> </tr> </table>			A. ACTIVE	B. CONSULTING	C. HONORARY	D. ASSOCIATE	E. COURTESY	F. INTERNS-IN-TRAINING	G. RESIDENTS-IN-TRAINING	H. OTHER	
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D. ASSOCIATE	E. COURTESY	F. INTERNS-IN-TRAINING										
G. RESIDENTS-IN-TRAINING	H. OTHER											
<b>XII.</b> Number of Employees (Full Time Equivalents)	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">A. REGISTERED PROFESSIONAL NURSES</td> <td style="width: 33%; border: none;">B. LICENSED PRACTICAL NURSES</td> <td style="width: 33%; border: none;">C. REGISTERED PHARMACISTS</td> </tr> <tr> <td style="border: none;">D. REGISTERED OCCUPATIONAL THERAPISTS</td> <td style="border: none;">E. QUALIFIED PHYSICAL THERAPISTS</td> <td style="border: none;">F. QUALIFIED MEDICAL SOCIAL WORKERS</td> </tr> <tr> <td style="border: none;">G. OTHER SOCIAL WORK PERSONNEL</td> <td colspan="2" style="border: none;">H. ALL OTHERS</td> </tr> </table>			A. REGISTERED PROFESSIONAL NURSES	B. LICENSED PRACTICAL NURSES	C. REGISTERED PHARMACISTS	D. REGISTERED OCCUPATIONAL THERAPISTS	E. QUALIFIED PHYSICAL THERAPISTS	F. QUALIFIED MEDICAL SOCIAL WORKERS	G. OTHER SOCIAL WORK PERSONNEL	H. ALL OTHERS	
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G. OTHER SOCIAL WORK PERSONNEL	H. ALL OTHERS											
<b>XIII.</b> Training Programs	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">           A. AFFILIATED WITH A MEDICAL SCHOOL            1 <input type="checkbox"/> Major            2 <input type="checkbox"/> Limited            3 <input type="checkbox"/> Graduate            4 <input type="checkbox"/> No Affiliation         </td> <td style="width: 40%; border: none;">           B. INTERN PROGRAM APPROVED BY:  <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">               1 <input type="checkbox"/> American Medical Association                2 <input type="checkbox"/> American Dental Association             </td> <td style="width: 50%;">               3 <input type="checkbox"/> American Osteopathic Association                4 <input type="checkbox"/> No Intern Program             </td> </tr> </table> </td> <td style="width: 35%; border: none;">           C. NUMBER OF RESIDENT PROGRAMS APPROVED BY:  <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">               1 <input type="checkbox"/> American Medical Association                2 <input type="checkbox"/> American Dental Association             </td> <td style="width: 50%;">               3 <input type="checkbox"/> American Osteopathic Association                4 <input type="checkbox"/> Check if No Resident Program             </td> </tr> </table> </td> </tr> </table>			A. AFFILIATED WITH A MEDICAL SCHOOL 1 <input type="checkbox"/> Major 2 <input type="checkbox"/> Limited 3 <input type="checkbox"/> Graduate 4 <input type="checkbox"/> No Affiliation	B. INTERN PROGRAM APPROVED BY: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">               1 <input type="checkbox"/> American Medical Association                2 <input type="checkbox"/> American Dental Association             </td> <td style="width: 50%;">               3 <input type="checkbox"/> American Osteopathic Association                4 <input type="checkbox"/> No Intern Program             </td> </tr> </table>	1 <input type="checkbox"/> American Medical Association 2 <input type="checkbox"/> American Dental Association	3 <input type="checkbox"/> American Osteopathic Association 4 <input type="checkbox"/> No Intern Program	C. NUMBER OF RESIDENT PROGRAMS APPROVED BY: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">               1 <input type="checkbox"/> American Medical Association                2 <input type="checkbox"/> American Dental Association             </td> <td style="width: 50%;">               3 <input type="checkbox"/> American Osteopathic Association                4 <input type="checkbox"/> Check if No Resident Program             </td> </tr> </table>	1 <input type="checkbox"/> American Medical Association 2 <input type="checkbox"/> American Dental Association	3 <input type="checkbox"/> American Osteopathic Association 4 <input type="checkbox"/> Check if No Resident Program		
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<b>XIV.</b> Non-Discrimination	<p>A. The regulation of the Department of Health, Education and Welfare issued under the authority of Title VI of the Civil Rights Act of 1964 requires every institution receiving financial assistance under any program administered by the Department to file an assurance of its compliance with the requirements of such regulation. The hospital insurance benefits program under Part A of Title XVIII of the Social Security Act is one of the programs which is covered by Title VI of the Civil Rights Act and to which the regulation is applicable. Have you already evaluated the availability of your services, your admission and room assignment practices, your practices in the granting of staff privileges, and your training programs (if any), and satisfied yourself that they are in compliance with the requirements of Title VI of the Civil Rights Act of 1964 and the applicable Federal Regulations?</p> <p style="text-align: center;">1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No</p> <p>B. Have you filed with any Federal or State agency an assurance of compliance with these requirements?</p> <p style="text-align: center;">1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      If "Yes," name of agency _____</p>											
SIGNATURE OF AUTHORIZED OFFICIAL		TITLE	DATE									

Figure 2.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

Form Approved.  
Budget Bureau No. 72-R725

## CERTIFICATION AND TRANSMITTAL

### TO BE COMPLETED BY STATE AGENCY

<b>1. NAME AND ADDRESS OF FACILITY</b>		<b>2. TYPE OF FACILITY</b> (a) <input type="checkbox"/> JCAH General Hospital (b) <input type="checkbox"/> Non-JCAH General Hospital (c) <input type="checkbox"/> Psych. Hospital (d) <input type="checkbox"/> TB Hospital (e) <input type="checkbox"/> ECF (f) <input type="checkbox"/> HHA (g) <input type="checkbox"/> HHA (Psych.) (h) <input type="checkbox"/> Independent Lab.																																
<b>3. TO:</b> BHI Regional Representative Regional Office,		<b>4. DATE OF APPLICATION</b>	<b>5. CERTIFICATION</b> <input type="checkbox"/> INITIAL <input type="checkbox"/> RECERTIFICATION	<b>6. STATE</b>																														
<b>7. PURSUANT TO PROVISIONS OF SEC. 1864 OF THE SOCIAL SECURITY ACT, AND UPON CONSIDERATION OF ALL FACTS, THE FACILITY IS CERTIFIED AS:</b> (a) <input type="checkbox"/> In substantial compliance with the conditions of participation (with no significant deficiencies) (b) <input type="checkbox"/> In substantial compliance with the conditions of participation (with correctable deficiencies) (c) <input type="checkbox"/> Meeting the conditions for special certification (limited access) (d) <input type="checkbox"/> Not (or no longer) in compliance with conditions of participation																																		
<b>8. SUPPLEMENTAL INFORMATION ON HOSPITALS AND ECF'S NOT IN COMPLIANCE</b> (a) <input type="checkbox"/> Facility is in conformance with 1861 (e) (1) (Definition of hospital) (b) <input type="checkbox"/> Facility is in conformance with 1861 (j) (1) (Definition of ECF) (c) <input type="checkbox"/> Hospital is in conformance with 1861 (e) (1-5) and (7) (Eligible for emergency services)																																		
<b>9.</b> <input type="checkbox"/> JCAH ACCREDITATION VERIFIED	<b>10. RECOMM. RE-SURVEY DATE</b>	<b>11. CONDITIONS OF PARTICIPATION WITH MAJOR DEFICIENCIES (Circle)</b> <i>(Complete when items 7b, 7c, or 7d are checked)</i> <table style="width: 100%; text-align: center;"> <tr> <td>I</td><td>II</td><td>III</td><td>IV</td><td>V</td><td>VI</td><td>VII</td><td>VIII</td><td>IX</td><td>X</td><td>XI</td><td>XII</td><td>XIII</td><td>XIV</td><td>XV</td> </tr> <tr> <td>XVI</td><td>XVII</td><td>XVIII</td><td>XIX</td><td>XX</td><td>XXI</td><td>XXII</td><td>XXIII</td><td>XXIV</td><td>XXV</td><td colspan="5"></td> </tr> </table>			I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV	XVI	XVII	XVIII	XIX	XX	XXI	XXII	XXIII	XXIV	XXV					
I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	XV																				
XVI	XVII	XVIII	XIX	XX	XXI	XXII	XXIII	XXIV	XXV																									
<b>12. EVIDENCE AND REASONING (Include results of consultation)</b>																																		

☐ CONT. ON ATTACHED SHEET

<b>13. PREPARED BY</b>	<b>14. DATE</b>	<b>15. REVIEWED BY</b>	<b>16. DATE</b>
<b>TITLE</b>	<b>TITLE</b>		

### TO BE COMPLETED BY REGIONAL OFFICE

<b>17. DETERMINATION OF ELIGIBILITY</b> (a) <input type="checkbox"/> Facility is eligible to participate (b) <input type="checkbox"/> Facility is not eligible to participate		<b>18. FACILITY IS IN COMPLIANCE WITH TITLE VI OF CIVIL RIGHTS ACT</b> <input type="checkbox"/>
<b>19. REGIONAL OFFICE REVIEW ACTION</b> (a) <input type="checkbox"/> Approved SA Certification No change (b) <input type="checkbox"/> Following consultation with SA, original certification of compliance changed to non-compliance (c) <input type="checkbox"/> Following consultation with SA, original certification of non-compliance changed to compliance		
<b>20. REMARKS</b>		

<b>21. PHS REVIEWER (where applicable)</b>	<b>22. DATE</b>	<b>23. DETERMINATION APPROVED</b>	<b>24. DATE</b>
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TO: BHI  
 Division of Methods and Procedures  
 Baltimore, Maryland 21235

FORM SSA-1539 (2-66)

of the individual necessitates the use of the most accessible hospital available which is equipped to furnish the services.”<sup>3</sup>

**Federal hospitals.**—By statute, hospitals owned or operated by the Federal Government are excepted from unqualified participation in the program unless the Secretary of Health, Education, and Welfare finds that a Federal hospital serves as a community institution. At the present time, two Federal hospitals in the District of Columbia and one in American Samoa, have been designated as “community” hospitals and participate fully in the programs. Otherwise, all other Federal hospitals are authorized to render emergency services only.

## CONTROL OF HOSPITAL FACILITIES

**Voluntary-church:** Hospitals whose governing authority is a nonprofit religious organization. For “Catholic” hospitals, this organization can be either a nursing order, national or international, or the local ecclesiastical authority, i.e., the local bishop.

**Voluntary-other:** Hospitals whose governing authority is a nonprofit organization other than a religious one.

**Proprietary:** Hospitals whose governing authority is an individual, partnership, or profit-making corporation.

**Government:** Hospitals whose governing authority is a unit of government. The unit may be a State, county, or city, or a city and county government jointly, or a hospital district established by a State agency.

## HOSPITAL FACILITIES AND SERVICES

**Adult hospital beds:** Includes beds regularly available for use by inpatients. These may be beds in isolation units, quiet rooms, reception and observation units, or any other such bed facilities that are set up and staffed for use by inpatients who have no other bed facility assigned to or reserved for them. Excludes bassinets and pediatric beds, and beds in facilities that are set up and staffed only for patients receiving special procedures for a portion of their stay, or which are used only as holding facilities prior to transfer to another hospital—for example, beds in labor rooms, postanesthesia or postoperative recovery rooms, or psychiatric holding beds.

**Blood bank:** Facility responsible for the drawing and processing of blood from donors, the typing and compatibility procedures, the titring of antibodies, the manufacture of blood products, and the transfusion service. May also include examinations concerned with genetic application of the blood group system.

**Clinical laboratory:** Laboratory responsible for

tests and procedures in the fields of microbiology, serology, clinical chemistry, hematology, and immunohematology.

**Pathology laboratory:** Laboratory responsible for tests and procedures in the fields of tissue pathology, exfoliative cytology, and autopsies.

**Electrocardiograph:** An instrument for making electrocardiograms, which are graphic tracings of the electric current produced by the contraction of the heart muscle and transmitted from a normal nodal base or from extra-node foci.

**Electroencephalograph:** An instrument used for the recording of the electric currents developed in the brain, by means of electrodes applied to the scalp, to the surface of the brain, or placed within the substance of the brain.

**Pharmacy:** A drug dispensary under the jurisdiction of a registered pharmacist regularly employed by the hospital.

**Occupational therapy departments:** Organized facilities and services of the hospital for the provision of occupational therapy services prescribed by physicians and administered by or under the direction of a qualified occupational therapist.

**Physical therapy department:** Organized facilities and services at the hospital for the provision of physical therapy services prescribed by physicians and administered by or under the direction of a qualified physical therapist.

**Intensive care unit:** A special area within a hospital for the treatment of critically ill patients who are under constant surveillance with emergency techniques and equipment immediately available. This unit is staffed by medical and paramedical personnel especially trained and selected for this unit.

**Organized outpatient departments:** Organized facilities and services of the hospital for the provision of medical care, including diagnosis or treatment, or both, primarily for ambulatory patients.

**Emergency department:** Organized facilities and services of the hospital for the provision of emergency outpatient services for conditions considered to require immediate care. Unit must be staffed 24 hours a day.

**Home care program:** An organized hospital program with facilities and services for the provision of treatment services to patients in their place of residence.

**Operating room:** The suite or suites where surgical procedures are performed. Includes equipment such as heart pumps, cardiac monitors, and other ancillary equipment required to evaluate patients’ tolerance to surgery.

**Postoperative recovery room:** A separate facility used exclusively to monitor patients recovering from anesthesia or to observe patients for postsurgical return to physiological stability. If these functions are combined with 24-hour intensive care, the facility is not a postoperative recovery room.

<sup>3</sup> See Section C5632, *State Operations Manual*, (HIM-7), Social Security Administration.

*Medical social service department:* Organized facilities and services for the provision of social services, under the direction of a qualified medical social worker.

*X-ray, diagnostic:* Use of radiographic and fluoroscopic equipment for the recognition and identification of internal conditions in a patient.

*X-ray, therapeutic:* Use of equipment such as radioactive cesium and iridium teletherapy units by physicians in the treatment of disease.

*Radioactive isotope facility:* A facility where artificial radioactive substances are used by physicians in the diagnosis and treatment of disease.

*Psychiatric inpatient care unit:* A specific section, ward, wing, floor, or separate building devoted primarily to the care of psychiatric inpatients.

*Cobalt and radium therapy:* Use of cobalt and natural radium therapy units by physicians in the controlled treatment of disease.

*Rehabilitation unit:* A unit that has as its primary objective the restoration of a patient to an optimal level of function through physical and restorative methods.

*Extended care unit:* A component in a hospital where medical care of an intensity less than that required in the hospital proper, but including 24-hour skilled nursing service and other therapeutic services, is required for the level of care appropriate to the status of the patient as he is recovering.

*Other services or facilities:* May include newly emerging services or facilities, such as self-care units, units for renal dialysis, open heart surgery, etc.

## ACCREDITATION AND AFFILIATION OF HOSPITALS

*Accreditation by JCAH.*—The Joint Commission on Accreditation of Hospitals (JCAH) evaluates hospitals for conformance to standards of accreditation. The Congress included a statutory condition in the Act whereby accreditation by the Joint Commission was deemed equivalent to meeting all the conditions for participation except the special conditions restricted only to tuberculosis and psychiatric hospitals, and to all applicant hospitals with regard to the conditions for utilization review.

*Affiliation with a medical school.*—A number of licensed medical schools maintain and staff component hospitals to provide the full complement of clinic training. In addition, other major hospitals have established affiliation agreements with medical schools where the hospitals have been selected by medical schools to serve as "major units" in the schools' teaching programs. These two categories of hospitals are categorized as "affiliated."

*Nonaffiliated, approved intern program.*—Includes nonaffiliated hospitals with intern programs approved by any one of the following: American Medical Association, American Dental Association, or the American Osteopathic Association.

*Nonaffiliated, approved resident program.*—Includes nonaffiliated hospitals offering approved residencies in the clinical division of medicine, surgery, and other special fields to provide advanced training in preparation for the practice of a specialty following internship.

## Provisions of the Law

The health insurance program for the aged, commonly called Medicare, was enacted on July 30, 1965, as Title XVIII of the Social Security Act, and became effective on July 1, 1966. The program, a part of the 1965 amendments (Public Law 89-97), makes available two separate but coordinated insurance coverages—hospital insurance, covering nearly all persons aged 65 and over, and supplementary medical insurance, covering those persons in this age group who enroll voluntarily and pay the premium. Changes in the program effective in 1968 were incorporated in the 1967 amendments to the Social Security Act (Public Law 90-248).

### Hospital Insurance Program

The hospital insurance program (Part A of Medicare) pays for a large portion of the costs of hospital and related post-hospital services. It is financed on a self supporting basis through a tax on a portion of current earnings, paid by employees, employers, and self-employed persons. The proceeds of this tax are placed in the Hospital Insurance Trust Fund, from which reimbursements for benefits and administrative expenses incurred under the program are paid. The trust fund is reimbursed from general tax revenues for the costs of providing coverage for persons who qualify for hospital insurance but who are not eligible for monthly social security or railroad retirement benefits.

### BENEFITS

*Inpatient hospital benefits.*—The program covers the cost of covered services in a participating hospital for up to 90 days in a “benefit period” (a period beginning with the first day of hospitalization and ending 60 days after discharge from a hospital or a skilled nursing home). Of the 90 days, full payment is made for the first 60 days of hospitalization after a deductible of \$40 has been paid. For each of the remaining 30 days in the benefit period, the patient pays a coinsurance amount of \$10 a day. The program provides the same benefits for emergency services rendered in a nonparticipating hospital.

Inpatient tuberculosis and psychiatric hospital services are also covered. However, there is a lifetime limit of 190 days of care in a psychiatric hospital.

Where an individual is a patient in a tuberculosis or psychiatric hospital at the time he becomes entitled to hospital insurance, the number of days he was such an inpatient in the 90-day period immediately prior to his eligibility are counted against his 90 days of entitlement in that benefit period.

Covered hospital services include hospital room and board in accommodations containing from two to four beds, nursing services except for private-duty nursing, drugs and biologicals, and all those services ordinarily furnished by a hospital to its inpatients. Coverage under the hospital insurance program does not include the services of physicians (including radiologists, anesthesiologists, pathologists, and physiatrists) except for those services provided by interns or residents in training under approved teaching programs in a hospital.

The cost of the first three pints of blood furnished a patient during a benefit period is a deductible amount unless the patient arranges for replacement. Charges for any additional blood are covered under the program.

*Outpatient hospital diagnostic benefits.*—These benefits cover the cost of tests and related services that are ordinarily furnished by a participating hospital to its outpatients for the purpose of diagnostic study. Such services are covered subject to a \$20 deductible and 20-percent coinsurance for diagnostic services furnished the beneficiary by the same hospital during a 20-day period. The deductible may be applied towards the \$50 annual medical insurance deductible.

*Post-hospital home health care benefits.*—These benefits cover the cost of visiting nurse services and related home health services for as many as 100 visits in a year following the patient's discharge from a hospital or extended care facility, provided he has been confined for at least 3 consecutive days in a hospital. A home health plan must be developed by a physician and implemented within 14 days after the patient's discharge from the hospital or extended care facility.

*Extended care facility benefits.*—The program pays for the reasonable cost of all covered inpatient services in participating extended care facilities (ECF) for up to 100 days of such care in any benefit period, following discharge from a hospital after a stay of 3 consecutive days or more, and admission to an ECF within 14 days of discharge. Full payment is made for

the first 20 days. For each of the remaining 80 days, the patient pays a coinsurance of \$5 a day.

### Supplementary Medical Insurance Program

The supplementary medical insurance program (Part B of Medicare) provides coverage of physicians' services, additional home health services, and a variety of other health services. Individuals 65 years of age and over may enroll in the program regardless of whether they are eligible for social security retirement benefits. The insured's monthly premiums are matched by the Federal Government and paid into the Supplementary Medical Insurance Trust Fund, which reimburses carriers for benefits and administrative expenses incurred under the program.

#### BENEFITS

The SMI program pays for 80 percent of the allowed charges for covered physician services and other medical services after the patient has met a deductible of \$50 during a calendar year. However, payment for outpatient psychiatric physician services is limited to the lesser of \$250 or 50 percent of the allowed charges in any year after the \$50 deductible has been met. The sum and percentage are derived from the statutory provision which permits an incurred expense for out-of-hospital treatment of mental illness of only \$312.50 or 62.5 percent of actual expenses in a calendar year. Since only 80 percent of allowed charges can be reimbursed, the effective maximum becomes \$250.

To preclude the possibility of having to meet a deductible twice in a short period of time, a "carry-over" provision is applied. Accordingly, covered expenses that are incurred in the last quarter of the year and counted toward the deductible in that year are also credited toward the deductible for the following year.

Covered under the program are such benefits as physicians' services, including home, hospital, and office visits; services and supplies, including drugs and biologicals that cannot be self-administered, that are furnished as a part of a physician's professional service, most commonly in his office, and either rendered without charge or included in the physician's bills; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy, including materials and the services of technicians; surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations; rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home); ambulance service in cases where the use of other methods of transportation is contraindicated by the individual's condition; prosthetic devices (other than dental) that replace all or part of an internal organ, including

replacement of such devices; leg, arm, back, and neck braces, and artificial legs, arms, eyes, including replacement if required because of a change in the patient's physical condition; and 100 home health visits during a calendar year—these visits being independent of those provided under the hospital insurance program.

#### Eligibility

*The hospital insurance program.*—Almost all persons aged 65 and over are eligible for benefits under the hospital insurance program. Included are those persons in this age group who are entitled to monthly social security cash benefits or payments from the railroad retirement system, regardless of whether they have applied for these cash benefits. A person could apply for hospital insurance protection even though he did not qualify for either social security cash benefits or a railroad retirement annuity if (1) he had attained age 65 by July 1, 1966, (2) he would become 65 years of age before 1968, or (3) he would attain age 65 after 1967 with not less than 3 quarters of social security coverage, whenever acquired, for each calendar year elapsing after 1965 and before the year in which he would attain age 65; however, hospital insurance protection could not go into effect until the individual attained age 65. These three classes of individuals were "deemed insured" under a special transitional provision.

Federal employees who retired from the Federal service after July 1, 1960, and who had the opportunity to be covered under the Federal Employees Health Benefits Act of 1959, are ineligible for hospital insurance benefits under the transitional provisions. Also ineligible are aliens with less than 5 years of continuous residence in the United States, and those persons convicted of crimes against the security of the United States.

Hospital insurance protection can be retroactive for as many as 12 months before the month an individual files his application for entitlement. For example, an individual may apply 11 months after he attains age 65 and still be entitled to benefits from the month he attained age 65.

*Supplementary medical insurance.*—Persons entitled to benefits under the hospital insurance program (Part A), retired Federal employees aged 65 or over, and persons not eligible for hospital insurance under the transitional provisions may voluntarily participate in the SMI program.

*Enrollment.*—An eligible person may enroll during the initial enrollment period, which begins with the third month preceding the one in which an individual attains age 65 and ends 3 months after the month of attainment, a total period of 7 months. If he enrolls during the 3 months prior to the month in which he attains age 65, his coverage is effective with the month in which he attains age 65; if he enrolls during the month he attains age 65, his coverage begins the following month; if he enrolls in any of the 3 months

after he attains age 65, his coverage begins from 2 to 3 months after enrollment, depending on how long he waited before enrolling.

A general enrollment period was set between October 1, 1967, and March 31, 1968, for those who did not enroll in the regular enrollment period, with comparable periods set to occur in every odd-numbered year from October through December. A person who enrolls during a general enrollment period may receive benefits starting on the first of July following the general enrollment period. An eligible individual must enroll within 3 years after the close of the first enrollment period in which he was entitled to enroll in order to become a beneficiary.

An initial general enrollment period was set up at the beginning of the program for people who had attained age 65 before March 1, 1966. This enrollment period began September 1, 1965, and ended on May 31, 1966, for coverage to begin with the initiation of the program on July 1, 1966.

A State may enroll otherwise eligible individuals who receive cash payments under public assistance programs if the State requests such a State-Federal enrollment agreement to be established and pays the necessary premiums.

Enrollment terminates with the beginning of the month following the month of death. In general, railroad retirement beneficiaries and individuals entitled to monthly cash social security benefits may terminate their enrollment voluntarily by notifying the Social Security Administration in writing during a general enrollment period of the desire to withdraw from the program. Other enrolled persons may terminate their coverage by withholding payment of premiums or by notifying the Social Security Administration in writing of the desire to withdraw from the program. An individual who previously has terminated his enrollment may re-enroll only in a general enrollment period beginning within 3 years of the date his previous enrollment had terminated. Re-enrollment, however, is allowed only once.

### Financing the Program

*Hospital Insurance.*—The hospital insurance program is financed on a long-range, self-supporting basis through a separate schedule of increasing tax rates on the first \$6,600 of earnings in employment covered under the Social Security Act with the same rate for employees, employers, and self-employed persons. The earnings base was raised in 1963 to \$7,800. This rate was 0.35 percent in 1966, 0.50 percent for 1967, and is scheduled to increase until it is 0.90 percent in 1987 and thereafter. The proceeds of this tax and that collected from the railroad retirement system are placed in a Hospital Insurance Trust Fund<sup>1</sup> from which reimbursements for all benefits and administrative expenses incurred under the hospital in-

surance program are paid. The Hospital Insurance Trust Fund is reimbursed from general tax revenues for the costs of providing coverage for the almost 2½ million persons who qualify for hospital insurance but who are not entitled to monthly social security or railroad retirement benefits, that is, those “deemed insured.”

*Supplementary Medical Insurance.* Premiums are paid into the Federal Supplementary Medical Insurance Trust Fund<sup>2</sup> by those persons enrolled for supplementary medical insurance, (or on their behalf) and a matching amount is paid from general revenues by the Federal Government.

The premiums of persons receiving social security cash benefits, railroad retirement, or Federal civil service annuities are deducted from their monthly benefit checks. Persons not receiving monthly benefits are billed quarterly for premiums by the Social Security Administration or Railroad Retirement Board and have a 90-day grace period in which to make payment. Premiums may be paid for as long as a year in advance, and for individuals financially unable to make quarterly payments, arrangements can be made for monthly payments.

The premium rate of the supplementary medical insurance program may be adjusted annually if medical costs rise. The law requires that the rate be set at an amount that will generate income to the fund sufficient to cover benefit payments and administrative costs incurred during the year. The monthly premium was set at \$3 beginning with July 1966 and remained at this level until April 1968 when it was raised to \$4 per month.

States are permitted to enter into agreements with the Secretary, based on a request made before January 1, 1970, to buy in—that is, to pay the medical insurance premiums—for public assistance recipients aged 65 or over who were receiving money payments under an approved public assistance plan and for all aged persons eligible to receive medical assistance under an approved Title XIX plan.

### Administration of the Program

*Hospital Insurance.*—Under the hospital insurance plan, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if approved by the Secretary and agreeable to the intermediary selected. In addition, a provider may deal directly with the Social Security Administration.

<sup>1</sup> 1967 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, U.S. House of Representatives Document Number 64.

<sup>2</sup> The 1967 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, U.S. House of Representatives Document Number 66.

The Secretary may enter into an agreement with a nominated organization if he finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for (1) furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services, (2) serving as a center for communicating with providers, and (3) making audits of provider records. Generally speaking, the Social Security Administration utilizes the services of the hospital insurance intermediary in making payments for home health and outpatient hospital services covered under the supplementary medical insurance program.

Payment may be made for a beneficiary for covered emergency inpatient hospital services where the hospital is not a participating facility and agrees not to charge the beneficiary for covered services. Such a hospital may be outside the United States if it is more accessible than the nearest hospital in the United States adequately equipped to treat the patient.

Requests for payment for covered services must be signed by the beneficiary (or someone for him, if he is unable to do so). Payments are made on the basis of reasonable costs for these services to participating providers of services, that is, hospitals, extended care facilities, and home health agencies, who have been certified for participation.

In some instances, hospitals may bill for physician services rendered to inpatients. In these cases, interim payment is made from the HI trust fund. Subsequently, funds are transferred from the SMI trust fund to the HI trust fund to cover the cost of these services.

The intermediary selected by the provider reviews the claims for payment and pays the provider. Actual payment is made on the basis of an interim rate established between the provider and the intermediary. Final settlement for each provider's operating year is made on the basis of a cost report submitted by the provider, and subject to an independent audit.

No payments can be made to Federal providers of services except for emergency services, unless this provider serves as a community institution. In addition, payment cannot be made to a provider for those services it is obligated to render at public expense under Federal law or contract.

*Supplementary Medical Insurance.*—Under the medical insurance program, the Secretary of Health, Education, and Welfare may enter into contracts with carriers for the performance of specified administrative functions. The carriers' principal function is to

determine whether charges are allowable (reasonable) and to make payments.

The carrier selected by the Secretary of Health, Education, and Welfare to serve as an intermediary determines the allowed charges for bills submitted for each medical care service covered by the program and pays 80 percent of this amount after the \$50 deductible has been met.

The allowed charge for the service may be paid to the patient, or the patient may assign the bill for collection to the physician or other supplier of the service if he is willing to accept assignment. In the former situation, the patient first pays the bill and submits the receipted bill to the carrier and is reimbursed, and, in the latter, the physician or other supplier submits the bill and is reimbursed. When the payment is made directly to the physician (or supplier) on assignment, the allowed charge determined by the carrier is the total charge. In both situations, the patient is responsible for the first \$50 of the charges for covered services he receives during the year and the amount of the bill over 80 percent of the allowed charges.

The law instructs the carrier to consider the following criteria in determining the "allowed" charge:

(1) the customary charge for the service generally made by the physician or other person furnishing such services; and

(2) the prevailing charge in the locality by other physicians and suppliers for similar services.

The law also specifies that the "allowed" or reasonable charge cannot be higher than the charge applicable for a similar service rendered under comparable circumstances to the carriers' own policy holders or subscribers.

Carriers also have the authority and responsibility to determine, in a given case, whether a claim is for a covered service and to deny claims for noncovered or excluded items or services. In addition, carriers are to assist in the application of safeguards against the furnishing of unnecessary services to eligible individuals.

Most services covered by the medical insurance program are rendered on a fee-for-service basis. However, services furnished under group practice prepayment plans are normally rendered in return for predetermined premium payments. In recognition of the need for special adaptation of the Medicare payment procedures for services rendered by group practice prepayment plans, the law provides that an organization which furnishes medical and other health services (or arranges for their availability) on a prepayment basis, may elect to be paid 80 percent of the reasonable cost of services in lieu of 80 percent of the allowed charge for such services.



## General Tables

### Notes

*Type of hospital.*—See page *x*.

*Type of control.*—See page *x*.

*Facilities and services.*—See page *xi*.

*Affiliation of hospital.*—See page *xii*.

*Geographic classifications.*—Based on the address of the agency.

*All areas:* Consists of the United States, Guam, Puerto Rico, Virgin Islands, and other outlying areas.

*United States:* Consists of the 50 States, and the District of Columbia.

*Other outlying areas:* Consists of American Samoa, the Canal Zone, Canton Island, Caroline Islands, Mariana Islands, Marshall Islands, Midway Islands, and Wake Island.

### Symbols

Quantity zero ----- —  
Quantity more than 0 but less than 0.05 ----- 0.0





Table 3.1.3 NUMBER OF TUBERCULOSIS HOSPITALS AND NUMBER OF BEDS BY CONTROL, REGION, DIVISION, AND STATE

[See NOTES preceding General Tables]

Region, division, and State	All tuberculosis hospitals	State hospitals		Local hospitals		All other hospitals <sup>1</sup>	
		Number	Adult beds	Number	Adult beds	Number	Adult beds
Total.....	123	63	17 397	51	8 275	9	633
United States.....	118	59	15 755	51	8 275	8	513
Northeastern States.....	17	11	3 351	6	918	-	-
North Central States.....	57	14	1 913	37	6 207	6	366
South.....	34	30	10 026	3	385	1	48
West.....	10	4	465	5	765	1	99
The Northeastern States:							
New England.....	7	4	373	3	477	-	-
Middle Atlantic.....	10	7	2 978	3	441	-	-
The North Central States:							
East North Central.....	48	8	1 126	34	5 338	6	366
West North Central.....	9	6	787	3	869	-	-
The South:							
South Atlantic.....	15	15	5 557	-	-	-	-
East South Central.....	13	10	1 748	3	385	-	-
West South Central.....	6	5	2 721	-	-	1	48
The West:							
Mountain.....	3	3	386	-	-	-	-
Pacific.....	7	1	79	5	765	1	99
New England:							
Maine.....	1	1	115	-	-	-	-
New Hampshire.....	1	1	82	-	-	-	-
Vermont.....	1	1	75	-	-	-	-
Massachusetts.....	4	1	101	3	477	-	-
Rhode Island.....	-	-	-	-	-	-	-
Connecticut.....	-	-	-	-	-	-	-
Middle Atlantic:							
New York.....	4	3	500	1	50	-	-
New Jersey.....	2	1	288	1	331	-	-
Pennsylvania.....	4	3	2 190	1	60	-	-
East North Central:							
Ohio.....	17	3	325	12	1 601	2	92
Indiana.....	5	2	226	3	367	-	-
Illinois.....	10	2	496	7	1 555	1	125
Michigan.....	7	1	79	6	1 380	-	-
Wisconsin.....	9	-	-	6	435	3	149
West North Central:							
Minnesota.....	4	2	115	2	204	-	-
Iowa.....	1	1	256	-	-	-	-
Missouri.....	1	-	-	1	665	-	-
North Dakota.....	-	-	-	-	-	-	-
South Dakota.....	-	-	-	-	-	-	-
Nebraska.....	1	1	130	-	-	-	-
Kansas.....	2	2	286	-	-	-	-
South Atlantic:							
Delaware.....	1	1	175	-	-	-	-
Maryland.....	1	1	500	-	-	-	-
District of Columbia.....	-	-	-	-	-	-	-
Virginia.....	4	4	1 040	-	-	-	-
West Virginia.....	1	1	390	-	-	-	-
North Carolina.....	4	4	1 494	-	-	-	-
South Carolina.....	-	-	-	-	-	-	-
Georgia.....	1	1	500	-	-	-	-
Florida.....	3	3	1 458	-	-	-	-
East South Central:							
Kentucky.....	7	6	909	1	32	-	-
Tennessee.....	5	4	839	1	200	-	-
Alabama.....	1	-	-	1	153	-	-
Mississippi.....	-	-	-	-	-	-	-
West South Central:							
Arkansas.....	1	1	572	-	-	-	-
Louisiana.....	1	1	351	-	-	-	-
Oklahoma.....	-	-	-	-	-	-	-
Texas.....	4	3	1 798	-	-	1	48
Mountain:							
Montana.....	1	1	195	-	-	-	-
Idaho.....	1	1	50	-	-	-	-
Wyoming.....	-	-	-	-	-	-	-
Colorado.....	-	-	-	-	-	-	-
New Mexico.....	-	-	-	-	-	-	-
Arizona.....	1	1	141	-	-	-	-
Utah.....	-	-	-	-	-	-	-
Nevada.....	-	-	-	-	-	-	-
Pacific:							
Washington.....	2	-	-	2	424	-	-
Oregon.....	1	1	79	-	-	-	-
California.....	4	-	-	3	341	1	99
Alaska.....	-	-	-	-	-	-	-
Hawaii.....	-	-	-	-	-	-	-
Outlying areas:							
Guam.....	-	-	-	-	-	-	-
Puerto Rico.....	5	4	1 642	-	-	1	120
Virgin Islands.....	-	-	-	-	-	-	-
Other outlying areas.....	-	-	-	-	-	-	-

<sup>1</sup>Includes voluntary and proprietary hospitals only.



**Table 3.1.5 NUMBER OF OTHER LONG-STAY GENERAL AND SPECIAL HOSPITALS AND NUMBER OF BEDS BY CONTROL, REGION, DIVISION, AND STATE**

[See NOTES preceding General Tables]

Region, division, and State	All other long stay general and special hospitals	Voluntary hospitals		Proprietary hospitals		State hospitals		Local hospitals	
		Number	Adult beds	Number	Adult beds	Number	Adult beds	Number	Adult beds
Total.....	189	83	9 482	19	1 644	34	12 304	53	17 444
United States.....	188	83	9 482	18	1 614	34	12 304	53	17 444
Northeastern States.....	66	28	4 463	1	71	20	8 958	17	6 229
North Central States.....	44	18	1 795	5	708	8	1 977	13	2 207
South.....	34	19	1 438	5	322	4	1 155	6	1 971
West.....	44	18	1 786	7	513	2	214	17	7 037
The Northeastern States:									
New England.....	33	11	1 596	-	-	16	6 833	6	1 245
Middle Atlantic.....	33	17	2 867	1	71	4	2 125	11	4 984
The North Central States:									
East North Central.....	35	13	1 309	4	389	5	1 254	13	2 207
West North Central.....	9	5	486	1	319	3	723	-	-
The South:									
South Atlantic.....	13	6	589	1	40	3	924	3	1 017
East South Central.....	7	4	133	-	-	-	-	3	954
West South Central.....	14	9	716	4	282	1	231	-	-
The West:									
Mountain.....	11	7	586	1	90	1	51	2	212
Pacific.....	33	11	1 200	6	423	1	163	15	6 825
New England:									
Maine.....	1	-	-	-	-	-	-	1	141
New Hampshire.....	1	1	29	-	-	-	-	-	-
Vermont.....	1	-	-	-	-	1	20	-	-
Massachusetts.....	19	6	860	-	-	8	3 405	5	1 104
Rhode Island.....	3	-	-	-	-	3	2 189	-	-
Connecticut.....	8	4	707	-	-	4	1 219	-	-
Middle Atlantic:									
New York.....	18	10	2 384	-	-	1	192	7	3 591
New Jersey.....	5	1	48	-	-	-	-	4	1 393
Pennsylvania.....	10	6	435	1	71	3	1 933	-	-
East North Central:									
Ohio.....	10	4	472	-	-	1	255	5	1 402
Indiana.....	3	2	319	-	-	-	-	1	50
Illinois.....	4	3	252	-	-	-	-	1	138
Michigan.....	16	3	209	3	339	4	999	6	617
Wisconsin.....	2	1	57	1	50	-	-	-	-
West North Central:									
Minnesota.....	3	2	203	-	-	1	156	-	-
Iowa.....	1	1	104	-	-	-	-	-	-
Missouri.....	1	1	116	1	319	1	526	-	-
North Dakota.....	2	1	63	-	-	1	41	-	-
South Dakota.....	-	-	-	-	-	-	-	-	-
Nebraska.....	-	-	-	-	-	-	-	-	-
Kansas.....	-	-	-	-	-	-	-	-	-
South Atlantic:									
Delaware.....	-	-	-	-	-	-	-	-	-
Maryland.....	4	1	114	-	-	3	924	-	-
District of Columbia.....	-	-	-	-	-	-	-	-	-
Virginia.....	1	-	-	-	-	-	-	1	344
West Virginia.....	1	1	38	-	-	-	-	-	-
North Carolina.....	3	2	167	-	-	-	-	1	73
South Carolina.....	1	1	80	1	40	-	-	-	-
Georgia.....	1	1	190	-	-	-	-	-	-
Florida.....	1	-	-	-	-	-	-	1	600
East South Central:									
Kentucky.....	2	1	30	-	-	-	-	1	150
Tennessee.....	5	3	103	-	-	-	-	2	804
Alabama.....	-	-	-	-	-	-	-	-	-
Mississippi.....	-	-	-	-	-	-	-	-	-
West South Central:									
Arkansas.....	1	1	94	-	-	-	-	-	-
Louisiana.....	1	-	-	1	91	-	-	-	-
Oklahoma.....	3	1	42	1	49	1	231	-	-
Texas.....	9	7	580	2	142	-	-	-	-
Mountain:									
Montana.....	2	1	38	-	-	-	-	1	14
Idaho.....	-	-	-	-	-	-	-	-	-
Wyoming.....	1	-	-	-	-	1	51	-	-
Colorado.....	5	4	482	1	90	-	-	-	-
New Mexico.....	-	-	-	-	-	-	-	-	-
Arizona.....	1	1	24	-	-	-	-	-	-
Utah.....	1	-	-	-	-	-	-	1	198
Nevada.....	1	1	42	-	-	-	-	-	-
Pacific:									
Washington.....	-	-	-	-	-	-	-	-	-
Oregon.....	2	1	44	1	20	-	-	-	-
California.....	25	7	773	5	403	-	-	13	6 573
Alaska.....	1	1	32	-	-	-	-	-	-
Hawaii.....	5	2	351	-	-	1	163	2	252
Outlying areas:									
Guam.....	-	-	-	-	-	-	-	-	-
Puerto Rico.....	1	-	-	1	30	-	-	-	-
Virgin Islands.....	-	-	-	-	-	-	-	-	-
Other outlying areas.....	-	-	-	-	-	-	-	-	-















































































**Table 3.1.8 FACILITIES AND SERVICES IN SHORT-STAY HOSPITALS BY BED SIZE, AND NUMBER OF HOSPITALS REPORTING EACH FACILITY, BY DIVISION—Con.**

[See NOTES preceding General Tables]

Division, facilities, and services	All short-stay hospitals	Bed size												
		Less than 25	25 to 49	50 to 99	100 to 149	150 to 199	200 to 249	250 to 299	300 to 399	400 to 499	500 to 749	750 to 999	1,000 to 1,999	2,000 or more
PACIFIC														
Total -----	761	92	199	218	79	58	36	26	28	15	7	2	1	-
Number reporting:														
Blood bank -----	492	41	111	149	61	40	28	21	19	12	7	2	1	-
Clinical laboratory -----	749	89	195	215	78	58	36	25	28	15	7	2	1	-
Pathology laboratory -----	462	19	73	131	70	55	36	26	28	14	7	2	1	-
Electrocardiograph -----	738	80	194	213	78	58	36	26	28	15	7	2	1	-
Electroencephalograph -----	280	10	28	63	41	37	33	22	23	13	7	2	1	-
Pharmacy -----	614	47	135	181	78	58	36	26	28	15	7	2	1	-
Occupational therapy department -----	121	3	13	18	6	20	12	13	18	9	6	2	1	-
Physical therapy department -----	457	17	68	135	68	56	36	26	28	14	6	2	1	-
Intensive care unit -----	313	2	34	73	51	47	34	24	27	12	7	1	1	-
Organized outpatient department -----	215	21	35	36	18	24	19	16	25	12	6	2	1	-
Emergency department -----	635	69	153	179	71	54	35	25	26	14	6	2	1	-
Home care program -----	56	2	10	8	2	9	7	4	7	3	3	-	1	-
Operating room -----	734	83	194	208	77	57	36	26	28	15	7	2	1	-
Post-operative recovery room -----	557	21	108	186	76	57	36	23	26	14	7	2	1	-
Medical social service department -----	135	10	7	20	14	23	12	13	19	8	6	2	1	-
X-Ray, diagnostic -----	748	86	196	216	78	57	36	26	28	15	7	2	1	-
X-Ray, therapeutic -----	235	1	10	48	32	38	32	24	26	14	7	2	1	-
Radioactive isotope facility -----	225	2	11	46	30	36	29	23	24	14	7	2	1	-
Psychiatric inpatient care unit -----	89	1	6	13	8	15	7	11	13	7	5	2	1	-
Cobalt and radium therapy -----	118	-	3	15	12	19	16	20	15	9	6	2	1	-
Rehabilitation unit -----	55	-	1	5	4	9	6	7	13	4	5	-	1	-
Extended care unit -----	140	16	30	36	15	16	5	7	8	4	3	-	-	-
Other services -----	105	6	10	32	15	9	11	5	8	4	4	-	1	-



















## Other Data Sources on the Health Insurance for the Aged Program

The *Health Insurance Statistics* series is designed to present current, quick-release data from the Medicare program. Two report series are issued in this format:

*The Health Insurance* (HI) series has included 26 releases since 1967. Issues released prior to 1970 are out of print, but available in many libraries.

*The Current Medicare Survey* (CMS) series, based on data from the continuing Current Medicare Survey, has included 13 releases since 1967. These issues are available in most libraries.

Future releases in the HI and CMS series may be obtained upon request to the Publications Staff, Office of Research and Statistics, Social Security Administration, Room 3643, HEW North Building, 330 Independence Avenue, S.W., Washington, D.C. 20201.

The *Social Security Bulletin*, published monthly, presents authoritative articles and analyses of medical care expenditures, prices, and utilization as well as current operating statistics from the Medicare program. The *Annual Statistical Supplement* to the *Bulletin* includes summary data on trust funds, services, claims, enrollment, average charges and participating providers of service under Medicare. The *Bulletin*, including the *Supplement*, is available in most libraries and by subscription at \$4 a year from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

The *Research and Statistics Note* series report on-going research, preliminary findings or provide addenda to material already published on the old-age, survivors, disability, and health insurance program. Designed to get information quickly into the hands of users, the series includes data on medical care prices, outlays, and expenditures. The series is available in many libraries. Future releases may be obtained upon request to the Publications Staff, Office of Research and Statistics, Social Security Administration, Room 3643, HEW North Building, 330 Independence Avenue, S.W., Washington, D.C. 20201.

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